Introduction to Your Policy

Welcome and thank you for choosing **Aetna** for your health benefits. We are pleased to provide you with this Policy. This Policy and other plan documents describe what is covered and how your plan works. All the conditions and provisions of the Policy apply to you and your eligible dependents covered under this plan.

What is Included

The Policy describes how to use your plan, what services are covered, the portion of the health care cost we pay, and the portion of the health care costs you will be required to pay.

This Policy takes the place of all policies **Aetna** may have provided to you earlier that describe this kind of insurance.

How to Use This Document

You should read this Policy carefully. You are responsible for understanding the terms and conditions in this Policy. This Policy also includes the *Insert A, Schedule of Benefits,* amendments, and riders.

This Policy contains exclusions and limitations. Please be sure to read the *Medical* and *Prescription Benefit Exclusions* sections carefully.

Common Terms

The Glossary section at the back of this document defines many terms used in this Policy. Defined terms appear in bolded print. Knowing these terms will

- Help you know how your plan works
- Give you useful information about your plan.

How to Contact Us

We are available to answer questions you may have related to your coverage or benefits. Please see the *Contact Us* section of the Policy for a listing of Our website, mailing address and telephone number.

COMPREHENSIVE MEDICAL EXPENSE POLICY
Policy Face Page

AETNA LIFE INSURANCE COMPANY
(a stock company)
151 Farmington Avenue
Hartford, Connecticut 06156

This Policy is underwritten by Aetna Life Insurance Company (called **Aetna**). This Policy is non-participating.

The Policyholder's coverage begins on the Effective Date as stated on the *Insert A*. The Policyholder's coverage will be continued until coverage ends as described in this Policy.

This Policy provides coverage for services and supplies described as **covered expenses** that are **medically necessary**. This Policy applies to coverage only and does not restrict your ability to receive health care services or **prescription drugs** that are not or might not be **covered expenses** under this Policy. Please read this Policy, including the attached *Schedule of Benefits*, as they explain the benefits in detail.

This Policy will be governed by applicable federal laws and the laws of the state of Nevada.

"You" "Your" and "Yours" refer to you and/or your covered dependents as defined in this Policy.

"We" "Our" or "Us" refers to **Aetna**.

Guaranteed Renewable
This Policy is guaranteed renewable at premium rates set by **Aetna**. However, **Aetna** may refuse renewal under certain conditions, as allowed by law.

You may keep this Policy in force by meeting the eligibility requirements and by making timely payment of the required premium. See the sections *Premium Payment, Coverage Termination and/or Rescission* and *Change of Residence*. You may renew this Policy by payment of the required premium by the end of the grace period of any premium due date.

We may make changes to the benefits and/or premium rates during the term of this Policy:

- As allowed by law and under the terms of this Policy.
- Upon renewal.

If we make any changes to the benefits, the changes apply to services that start on or after the effective date of the Policy changes. These changes, including any decrease in benefits or removal of benefits, apply to:

- Any claims or expenses
- Any incurred services
- Any supplies furnished.

There are no vested rights to receive any benefits described in this Policy after the date the Policy changes or terminates. This applies even if the claim or expense took place after the Policy changes or ends but before you received the changed or new plan documents.

Your Application
The application you submitted for coverage has now become part of the Policy, which has been issued relying on the information given in your answers to all questions in the application process for coverage under this Policy.

By applying for coverage under this Policy, or accepting its benefits, you (or your representative seeking coverage on your behalf) represent that all information contained in your application and statements submitted to **Aetna** as part of your application for this Policy is true, correct and complete to the best of your knowledge and belief and agree to all terms, conditions and provisions of the Policy.

It is your responsibility to review the application that you submitted to **Aetna** for accuracy and completeness. It is important that you notify **Aetna** immediately of any inaccurate statements that you find in your application.

Any intentional misrepresentation of material fact or fraud in the information and/or answers submitted as part of the application and/or application process (subject to the incontestability provision) may, at **Aetna**'s discretion, result in the rescission of this Policy, and in federal and State prosecution in accordance with federal and State laws.

If you need a copy of your application, it can be obtained by contacting Member Services at the toll free number on the back of your ID card.

Right of Examination
If you are not satisfied with this Policy, you may return this Policy to the agent through whom you applied for coverage or to **Aetna** at the address shown below within 10 days after the date of delivery. **Aetna** will refund any premium paid. You may be responsible for the cost of any **covered expenses** paid on behalf of you or your covered dependent. The Policy will be deemed void from the original Effective Date.

[Aetna
Attn: Enrollment
P.O. Box 730
Blue Bell, PA 19422]

Mark T. Bertolini
Chairman, Chief Executive Officer and President

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Important Information Regarding Your Coverage

Register on [Aetna Navigator Secure Member] Website

Register for [Aetna Navigator at www.aetna.com] for secure Internet access to reliable health information tools and resources. Aetna Navigator online tools will help make it easier for you to make informed decisions about your health care, view claims, research care and treatment options and access information on health and wellness.

Pay Your Premium

Benefits are available to you only if you remain eligible for coverage under this Policy. Subject to the grace period, you are required to pay the premium payment to Us before its due date for your coverage to remain in effect.

Understand Benefits Available to You

Understand how to access care in routine and emergency situations. Network and out-of-network benefits are paid differently, which may impact your financial responsibility.

Locate a Provider

Locate **physicians** and other health care professionals in your area who participate in your plan by visiting [DocFind® at www.aetna.com]/custom/docfind/advplans.com].

Show Your ID Card

You will receive an ID card. You should show your ID card when you receive services from health care providers as it identifies you as an **Aetna** member. This will allow the provider to bill the correct entity for services delivered which will help avoid any potential delays in processing any claims. If you have not received your ID card or if your card is lost or stolen, you can print out a temporary ID card by logging into the [Aetna Navigator secure member website at www.aetna.com] or notify us immediately and a new ID card will be issued.

Pay Your Cost Share

You are responsible for paying any **deductible**s, **copayments** and **coinsurance** for network and out-of-network benefits. Additionally, you are financially responsible for expenses not covered under this plan, including but not limited to those services listed under *Medical Benefit Exclusions and Pharmacy Benefit Exclusions.*

Inform Us of Any Changes

If there are any changes which will affect you or your covered dependent's eligibility, you must contact Us within 31 days of the date of the change. This may include changes in:

- Address;
- Phone number;
- Marital status;
- Divorce status; or
- Dependent status.

Enroll in EFT
Convenient and automatic premium payments can be directly deducted from your checking account using Electronic Funds Transfer (EFT). Visit [www.aetna.com] to print out the EFT authorization form which includes instructions on how submit a completed form. EFT saves you money by eliminating the cost of checks, envelopes or postage. You will not receive a paper invoice when you are enrolled in EFT.

Who is Eligible to be Covered

Throughout this section you will find information on who can be covered under this Policy, and what to do when there is a change in your life that affects coverage.

The Policyholder is:

- A resident of the State of Nevada;
- age 19 and over*;
- Not eligible for or enrolled in Medicare at the time of application;
- Listed as the applicant on the application;
- Approved by **Aetna.**
- [A Costco Member in good standing.]

*In the case of child only coverage, the parent or legal guardian in whose name the coverage under the plan is issued is considered the Policyholder. The child covered under the plan may be under age 19.

Covered dependents are the following members of the Policyholder's family who are eligible, are residents of the state in which the Policy was issued and have been approved by **Aetna**:

- Your spouse.
- Your domestic partner. A domestic partner under this Policy is a person of the same or opposite sex as the Policyholder, who has been issued a Certificate of Registered Domestic Partnership with the Policyholder by the State of Nevada, Office of the Secretary of State.
- Your or your covered spouse's, or your covered domestic partner's children who are under [26-30] years of age.

Eligible dependent children include:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Any children for whom you are responsible under court order.

Special Circumstances:

- Newborns of the Policyholder, covered spouse or covered domestic partner are automatically covered for the first [31-60] days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING **AETNA** IN WRITING WITHIN [31-60] DAYS OF BIRTH. THE

POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.

- A child being adopted by the Policyholder or covered domestic partner will have coverage for the first [31-60] days from the date of adoption, if the child was not placed in the home of the Policyholder or covered domestic partner before adoption. A child placed with the Policyholder or covered domestic partner for the purpose of adoption will have coverage up to 31 days from the moment of placement as certified by the public or private agency making the placement. The coverage of a child place with the Policyholder for the purpose of adoption ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN [31-60] DAYS OF THE DATE THE POLICYHOLDER'S OR COVERED DOMESTIC PARTNER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE THE POLICYHOLDER'S OR COVERED DOMESTIC PARTNER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.
- Newborns who are the children of a Policyholder's covered dependent under this policy are not covered after the first [31-60] days under this policy unless the Policyholder or the Policyholder's covered spouse or covered domestic partner has obtained court ordered custody of the child.
- Coverage for handicapped dependent children may continue after your dependent child reaches the limiting age. See *When Coverage Ends* for more information.

Effective Date of Coverage for Dependents

Coverage for your dependents will take effect on the first or the 15th of the month after approved by **Aetna** and consistent with your Premium Due Date (as shown on your *Insert A*).

Notice of Change in Eligibility

You must notify **Aetna** of all changes affecting your or any covered dependent's eligibility under this Policy within [31-60] days of the change.

Failure to notify **Aetna** of the change within the designated [31-60] day timeframe may result in **Aetna**'s denying the request for a retroactive eligibility date.

[What Happens if Your Costco Membership Lapses

The Costco Personal Insurance Plan is made available to members of Costco Wholesale. As long as you continue to be a member of Costco Wholesale, you will remain eligible to purchase coverage under this plan.]

Requirements for Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the **illness** or **injury** itself. This means that **Aetna** will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, **injury** or **illness** which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by **Aetna**. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. **Aetna** makes no express or implied warranties concerning the outcome of any covered services or supplies.

To be covered by the plan, services and supplies and **prescription drugs** must meet the following requirement:

The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease
- Not primarily for the convenience of the patient, **physician** or other health care provider;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Notes:
To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be ***covered by the plan***. For a service or supply or **prescription drug** to be covered, it must:

    - Be included as a **covered expense** in this Policy;

    - ***Not*** be an excluded expense under this Policy. Refer to the *Pediatric Dental Benefit Exclusions, Medical Benefit Exclusions* and *Pharmacy Benefit Exclusions* sections of this Policy for a list of services and supplies that are excluded;

    - ***Not*** exceed the maximums and limitations outlined in this Policy. Refer to the *What the Medical Benefit Covers* and *What the Pharmacy Benefit Covers* sections and the *Summary of Benefits* for information about certain expense limits; and

    - Be obtained in accordance with all the terms, policies and procedures outlined in this Policy.

2. The service or supply or **prescription drug** must be provided while ***coverage is in effect***. See the *Who is Eligible to be Covered, Coverage Termination and/or Rescission* and *When Coverage Ends* sections for details on when coverage begins and ends.

Not every service or supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain health services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Medical Benefit Covers, What the Pharmacy Benefit Covers* sections as well as the *Schedule of Benefits* for the plan limits and maximums.

Your Medical Benefit

The medical expenses incurred for the services and supplies described and shown in this section are **covered expenses**. Refer to the *Schedule of Benefits* for details about **deductible**, **copayments**, **coinsurance** and benefit maximums. The plan does not cover all healthcare services, **prescription drugs**, medications and supplies. Refer to the *Pediatric Dental Benefit Exclusions*, *Medical Benefit Exclusions* and *Pharmacy Benefit Exclusions* sections of this Policy.

Getting Started: How Your Medical Benefit Works

How Your Open Access Gatekeeper PPO Plan Works

This Open Access Gatekeeper Preferred Provider Organization (PPO) medical plan provides access to covered services and supplies through a network of health care providers and facilities. These **network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to covered persons at a reduced fee called the **negotiated charge**. This Open Access Gatekeeper PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your cost-sharing will generally be lower when you use **network providers**.

Cost Sharing

You share in the cost of your benefits. Cost sharing amounts and provisions are described in the Schedule of Benefits. They will differ for services in the network and out of the network. Costs will generally be lower in the network.

Using Network Providers

First, you must satisfy any **deductible** that applies before the plan will start to pay benefits. Then, you will be responsible for your **coinsurance** for any **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that **covered expense**. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** that applies to your plan.

For certain types of services and supplies a **copayment** applies in the network. You are responsible for any **copayments** that apply. See the *Schedule of Benefits* for **copayments**.

The **maximum out-of-pocket limit** applies to covered services and supplies that were received in the **calendar year**. Once the **maximum out-of-pocket limit** is met for the **calendar year**, the plan pays 100% for **covered expenses** that:

- Have dates of service in that **calendar year**
- Apply toward the **maximum out-of-pocket limit**.

Some expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* section to find out what **maximum out-of-pocket limits** apply to your plan, and which expenses do not apply to the **maximum out-of-pocket limit**.

The plan pays for some **covered expenses** up to a maximum benefit level. You must pay any expenses over the maximum. For the maximum benefit levels, refer to these sections:

- *What the Medical Benefit Covers*
- *What the Pharmacy Benefit Covers*
- *Schedule of Benefits*

You may be billed for any **deductible**, **copayment** or **coinsurance** amounts. You may also be billed for any non-**covered expenses** that you incur.

Finding a Network Provider

You may search online for the most current list of **network providers** in your area by using [DocFind®], **Aetna's** online provider **directory,** or by referring to the *Contact Us* section. **Aetna** cannot guarantee the availability or continued participation of a particular provider. **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

Ongoing Reviews

Aetna conducts reviews of those services and supplies that are recommended or provided by health professionals to determine whether such services and supplies are **covered expenses** under this Policy. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna.** Please refer to the *Appeals Procedure* section of this Policy.

To better understand the choices that you have with your Open Access Gatekeeper PPO plan, please carefully review the following information.

The Primary Care Physician (PCP):

You may choose to access care through a **primary care physician (PCP)** from **Aetna**'s network of providers. A **PCP** may be a general practitioner, family **physician**, internist, pediatrician and, if available within the network, an obstetrician or gynecologist. Your **PCP** provides routine preventive care and will treat you for **illnesses** or **injuries**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or by directing you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on Aetna's website [www.aetna.com] or by calling [Member Services] toll-free number on your ID card. The change will become effective upon Aetna's receipt and approval of the request.

Specialists and Other Network Providers:

You may also directly access **specialists** and other health care professionals in the network for covered services and supplies under this Policy. Refer to [DocFind®] to locate network **specialists**, providers and **hospitals** in your area.

Refer to the *Schedule of Benefits* for benefit limitations and out-of-pocket costs applicable to your plan.

- Certain health care services such as **hospitalization** and certain other outpatient services require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the **network provider's** responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Medical Precertification* section for more information on the **precertification** process and what to do if your provider's request for **precertification** is denied.
- You will not have to submit medical claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** or **copayments**, if any.

You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **coinsurance** or other non-**covered expenses** you have incurred. You may elect to receive this notification electronically by registering on [**Aetna** Navigator at www.aetna.com] or through the mail.

Continuity of Care

When your **hospital** or **physician** stops participation with **Aetna** as a **network provider** for reasons other than:

- Imminent harm to patient care
- Determination of fraud
- Final disciplinary action by a state licensing board that impairs the heath professional's ability to practice;

Aetna will continue coverage for an ongoing course of treatment with your current **hospital** or **physician** during a transitional period. Coverage shall continue for up to 120 days from the date of notice to you from **Aetna** that the provider terminated participation with **Aetna** as a **network provider.**

If your medical condition is pregnancy, coverage shall continue for a transitional period of 45 days after the date of delivery, or the date of the end of the pregnancy if the pregnancy does not end in delivery. The coverage will be authorized by **Aetna** for the transitional period only if the **hospital** or **physician** agrees:

- To accept reimbursement at the **negotiated charge** and cost sharing applicable prior to the start of the transitional period as payment in full;
- To not seek payment from you for any medical services provided by your **hospital** or **physician** that the provider could not have received from you were they still under contract with **Aetna**;
- To adhere to quality standards and to provide medical information related to such care; and
- To adhere to **Aetna's** policy and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this Policy.

With regards to the continuity of coverage provisions described above, the notice of the event provided to you by **Aetna** will include specific instructions on how to request continuity of coverage during the transitional period.

Using Providers Outside of the Network

You also have the choice to access licensed providers, **hospital**s and facilities outside the network. You will still be covered when you use **out-of-network providers** for **covered expenses**. Your out-of-pocket costs, like **deductibles** and **coinsurance**, will generally be higher.

Understanding Medical Precertification

Precertification

Certain services, such as inpatient **stays,** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced]. The list of services requiring **precertification** appears below.

Precertification for **emergency** services is not required, however, we do suggest that you, or your **physician** or facility call as soon as reasonable possible.

Important Note

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice facility**;
- **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**;
- Complex imaging;
- Comprehensive Infertility Services;
- Cosmetic and reconstructive surgery;
- Emergency transportation by airplane;
- Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications);
- Kidney dialysis;
- Bariatric surgery (obesity);
- Outpatient back surgery not performed in a **physician's** office;
- Sleep studies
- Knee surgery; and
- Wrist surgery.

The Out-of-Network Precertification Process

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on the back of your ID card. This call must be made:

For non-**emergency admission**s:	You or a member of your family, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency admission**:	You or a member of your family, your **physician** or the facility should call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You or a member of your family, your **physician** or the facility will need to call before you are scheduled to be admitted.
For outpatient non-emergency medical services requiring **precertification**:	You or a member of your family, your **physician** or the facility must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision**,** where required under applicable State law. If your **precertified** services are approved**,** the approval is valid for [30-180] days as long as you remain enrolled in the plan**.** Premium that is due and unpaid at the time the **precertified** treatment/services are performed must be paid in full within the required timeframe.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on the back of your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna**'s decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure* section of this Policy.

Failure to Precertify Affects Your Benefits

If you fail to obtain required **precertification** prior to incurring out-of network medical expenses, a **precertification** benefit reduction will be applied to the benefits paid. This means **Aetna** will reduce the amount paid towards your coverage.

You are responsible for obtaining the necessary **precertification** from Aetna prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with Aetna prior to the procedure, that the provider has obtained **precertification** from Aetna. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced].

How Your Benefits for Inpatient and Outpatient Care, Procedures and Treatment are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** for outpatient or inpatient services is not obtained.

If **precertification** is:	then the expenses are:
Requested and approved by **Aetna**	Covered up to the maximums shown in the *What the Medical Benefit Covers* or *Schedule of Benefits* sections.
Requested and denied	Not covered, may be appealed.
Not requested, but would have been covered if requested	Covered (after a **precertification** benefit reduction is applied*) up to the maximums shown in the *What the Medical Benefit Covers* or *Schedule of Benefits* sections.
Not requested, would not have been covered if requested	Not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible** or **coinsurance** or **maximum out-of-pocket limit**.

Important Note:
Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Notice of Precertification Denial

A written notification of a **precertification** denial shall include, in clear terms, all reasons for the denial, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the denial, and the instructions for requesting a written statement of the clinical review criteria used to make the denial. **Aetna** shall provide the clinical review criteria used to make the **precertification** denial to any person who received the notification of the denial and who follows the procedures for a request.

Understanding Emergency and Urgent Care Coverage

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the **service area**, for:

- An **emergency medical condition**
- An **urgent condition**.

In Case of a Medical Emergency

When **emergency care** is **medically necessary**, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** or **PCP** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** or **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** or **PCP** as soon as reasonably possible.

Important Note:

If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Refer to the *Schedule of Benefits* for cost-sharing information that applies to this Plan.

In Case of an Urgent Condition

Call your **physician** or **PCP**, if you think you need **urgent care**. **Network providers** are required to provide **urgent care** coverage 24 hours a day, including weekends and holidays. **Physicians** usually provide coverage 24 hours a day, including weekends and holidays for **urgent care**. You may contact any **physician** or **urgent care provider** in or out-of the network for an **urgent care** condition if you cannot reach your **physician** or **PCP**. If it is not feasible to contact your **physician** or **PCP**, please do so as soon as possible after **urgent care** is provided. If you need help finding a network **urgent care provider** you may call [Member Services] at the toll-free number on the back of your ID card, or you may access [DocFind®], **Aetna's** online provider **directory**.

If access to a **network provider** for treatment of an **urgent condition** is not possible, you may request authorization from **Aetna** to see an out-of-network **urgent care provider** so that such treatment charges may be paid at the network level of benefits. To request authorization, please call Members Services at the toll-free number on the back of your ID card. If it is not feasible to request authorization prior to treatment, then it should be done as soon as possible after treatment but not later than:

- The next day during normal business hours.
- If you are confined in a **hospital** directly after receiving **urgent care**, not later than 48 hours following the start of the confinement unless it is not possible for you to request authorization within that time. In that case, it must be done as soon as reasonably possible.

However, if the treatment is received or the confinement occurs on a Friday or Saturday, authorization must be requested within 72 hours following treatment or the start of the confinement.

If you do not request authorization from **Aetna** to see an out-of-network **urgent care provider**, charges incurred for **urgent care** will be paid at the plan's out-of-network benefit level.

Please contact your **physician** or **PCP** as soon as reasonably possible after medical care is provided to treat an **urgent condition**.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an **emergency medical condition** or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** or **PCP** for any **medically necessary** follow-up care.

For coverage purposes, follow-up care is treated as an expense for routine **illnesses** or **injuries**. If you access a **hospital** emergency room or **urgent care provider** for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductibles** and **coinsurance** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as X-rays, should not be provided by an emergency room facility.

What The Medical Benefit Covers

Open Access Gatekeeper PPO Medical Plan

Only expenses incurred for the services and supplies shown in this section are **covered expenses**.

Refer to the *Schedule of Benefits* for details about **deductible**, **copayments**, **coinsurance** and benefit maximums. Not all healthcare services are covered. Please refer to *Medical Benefit Exclusions* for additional information.

Important Notes:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force; and
   - Health Resources and Services Administration;

   as referenced throughout this *Preventive Care* section may be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the calendar year, one year after the recommendation or guideline is issued.

2. If any *diagnostic* x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the *Preventive Care Benefits* described below, those x-rays, lab or other tests or procedures will *not* be covered as *Preventive Care* benefits. Those that are **covered expenses** will be subject to the cost-sharing that applies to those specific diagnostic services under this plan.

3. Refer to the *Schedule of Benefits* for information about cost-sharing and maximums that apply to *Preventive Care* benefits.

Preventive Care Benefits

This section on *Preventive Care* describes the **covered expenses** for services and supplies provided when you are well.

Routine Physical Exams

Covered expenses include charges made by your **physician**, **primary care physician** (**PCP**) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

  - Screening and counseling services, such as:
    - Interpersonal and domestic violence.
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check-up.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams

Preventive Care Immunizations

Covered expenses include charges made by your **physician, primary care physician (PCP)** or a facility for:

- Immunizations for infectious diseases;
- The HPV vaccination for ages [9 through 26-30]; and
- Materials for the administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations
Immunizations that are not considered Preventive Care such as those required due to employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your **physician**, **primary care physician** (**PCP**) obstetrician, or gynecologist for a routine well woman preventive exam office visit, including Pap smears, cytologic screenings, and rectovaginal pelvic exams for women age 25 and over who are at risk of ovarian cancer in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this plan.
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury.**
- Exams given during your **stay** for medical care.
- Services not given by a **physician** or under his or her direction.
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services

Covered expenses include charges made by your **physician**, **primary care physician** (**PCP**) in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention
- Medical nutrition therapy

- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits***.**

Misuse of Alcohol and/or Drugs
Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits***.**

Use of Tobacco Products
Screening and counseling services to aid you to stop the use of tobacco products.

Coverage includes:
- Preventive counseling visits
- Treatment visits
- Class visits;

to aid you to stop the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits***.**

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this plan.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:
- One baseline mammogram for covered females age 35 to 40
- One annual mammogram for covered females age 40 and over
- Fecal occult blood tests
- Digital rectal exams
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force.
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Prostate and colorectal cancer screenings and laboratory services in accordance with:

(a) The guidelines concerning these cancer screenings which are published by the American Cancer Society; or
(b) Other guidelines or reports concerning these cancer screenings which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this plan.

Important Notes:
1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Preventive Care*.
2. For details on the frequency and age limits that apply to *Routine Physical Exams* and *Routine Cancer Screenings*, contact your **physician** or [Member Services] by logging onto the **Aetna** website [www.aetna.com] or calling the toll-free number on the back of your ID card.

Prenatal Care

Prenatal care will be covered as *Preventive Care* for services received by a pregnant female in a **physician's**, **primary care physician's** (**PCP**), obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this *Preventive Care* benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:

- Services which are covered to any extent under any other part of this plan.
- Pregnancy expenses *(other than prenatal care as described above).*

Important Notes:
Refer to the *Pregnancy Expenses* and *Medical Benefit Exclusions* sections of this Policy for more information on coverage for pregnancy expenses under this plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the 60 day period directly following the child's date of birth. **Covered expenses** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits*.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows:

Breast Pump

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years following the date of the birth; or
  - A manual breast pump.
- If an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Limitations:

Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this plan.

Important Notes:

If a breast pump service or supply that you need is covered under this Plan but not available from a **network provider** in your area, please contact:

- Your **physician** or **PCP**; or
- [Member Services] by [logging on to *Aetna Navigator at www.aetna.com]* or at the toll-free number on the back of your ID card for assistance];

to get an approval from **Aetna** to go to an **out-of-network provider** and receive the network benefit level as shown in your *Schedule of Benefits*.

Family Planning Services - *Female Contraceptives*

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies

covered under this *Preventive Care* benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, **primary care physician's** (**PCP**), obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your *Schedule of Benefits***.**

The following contraceptive methods are **covered expenses** under this *Preventive Care* benefit:

Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives
Covered expenses include charges made by a **physician** for female contraceptive generic **prescription drugs** and generic devices and brand name devices. Coverage includes the related services and supplies needed to administer the covered contraceptive.

Important Notes:
Refer to the section *"Your Pharmacy Benefits"* later in this Policy for additional coverage of female contraceptives.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Additional Covered Medical Expenses

Family Planning Services - *Other*

Covered expenses include charges for the following family planning services, even though not provided to treat an **illness** or **injury**:

- Voluntary sterilization for males.

Limitations:
Not covered under this benefit are charges incurred for:

- Voluntary termination of pregnancy;
- Male contraceptive methods or devices;
- Reversal of voluntary sterilization procedures, for males and females including related follow-up care;
- Charges for services which are covered to any extent under any other part of this plan; and
- Charges incurred for family planning services while confined as an inpatient in a **hospital** or other facility.

Vision Care Benefits

Pediatric Routine Vision Exams

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction and glaucoma testing.

Pediatric Vision Care Services and Supplies

Covered expenses include charges for the following vision care services and supplies:

- *Preferred* eyeglass frames, **prescription** lenses or **prescription** contact lenses identified by a vision **network provider**. These are eyeglass frames, **prescription** lenses, or **prescription** contact lenses that are covered at 100% by a vision **network provider**.
- *Non-Preferred* eyeglass frames, **prescription** lenses or **prescription** contact lenses that are not identified as *Preferred* by a vision **network provider**.

Coverage includes charges incurred for:

- Non-conventional **prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses.Aphakic **prescription** lenses prescribed after cataract surgery has been performed.Low vision services.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

A listing of the locations of the vision **network providers** under this Plan can be accessed at the [www.aetna.com] website. Be sure to look at the appropriate vision **network provider** listing that applies to your plan, since different **Aetna** plans use different networks of providers. You must present your ID card to the vision **network provider** at the time of service.

This benefit is subject to the maximums shown on the Schedule of Benefits. As to coverage for **prescription** lenses in a calendar year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for services and supplies:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses.
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes.

Adult Routine Vision Exams

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction and glaucoma testing.

Important Notes:
Refer to the *Schedule of Benefits* for any cost-sharing, age limits, exam frequency limits and maximums

that apply to vision exams, services and supplies.

Physician Services

Physician Visits

Covered expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital**, or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Allergy testing and allergy injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Important Note:

For a description of the preventive care expenses covered under this Plan, refer to the *Preventive Care Benefits* section in this Policy.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your **surgical procedure**;
- Preoperative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the **surgery**.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician,** other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in stress management.

  The stress management counseling sessions will:
  - help you to identify the life events which cause you stress (the physical and mental strain on your body.); and
  - teach you techniques and changes in behavior to reduce the stress.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for services and supplies

furnished in a group setting for screening and counseling services.

Important Note:
- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this Policy and the *Screening and Counseling Services* benefit for a description of these services.
- These services may also be obtained from your **physician** or **PCP**.

E-Visits

Covered expenses include charges made by your **physician** or **PCP** for a routine, non-emergency medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider **directory** or online in [DocFind®]. Please refer to the *Contact Us* section for additional information.

Hospital Expenses

Covered expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:
- Services of the **hospital**'s nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include **hospital** charges for other services and supplies provided, such as:
- **Ambulance** services;
- **Physicians** and surgeons;
- Operating and recovery rooms;
- Intensive or special care services;
- Administration of blood and blood products, but not the cost of the blood or blood product;
- Radiation therapy;
- Speech therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- Radiological services, laboratory testing and diagnostic services;
- Medications;
- Intravenous (IV) preparations;
- Discharge planning.

Hospital admissions need to be **pre-certified** by **Aetna**. Refer to *Understanding Medical Precertification* for details about **precertification**.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Notes:
The plan will only pay for nursing services provided by the **hospital** as part of its charge.

Refer to the *Schedule of Benefits* for your cost-sharing and maximum benefit limits.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room staff **physicians** services;
- **Hospital** nursing staff services; and
- Staff radiologists and pathologists services.

Please contact your **physician** after receiving treatment for an **emergency medical condition**.

Important Notes:
If you visit a **hospital** emergency room for a non-**emergency medical condition**, the plan will not cover your expenses. No other plan benefits will be paid for non-**emergency care** in the emergency room. Refer to your *Schedule of Benefits* for the cost-sharing information that applies to you.

Coverage for Urgent Conditions

Covered expenses include charges made by an **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities;
- Use of urgent care facilities;
- **Physician** services;
- Nursing staff services; and
- Radiologist and pathologist services.

Please contact your **physician** after receiving treatment of an **urgent condition**.

Important Notes:
If you visit an **urgent care provider** for a non-**urgent condition**, the expenses will not be covered

under the plan. Refer to your *Schedule of Benefits* for the cost-sharing information that applies to you.

Pregnancy Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **hospital** for a minimum of:

- 48 hours after a vaginal delivery;
- 96 hours after a cesarean section; and
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for 1 post-delivery home visit by a health care provider.

Pregnancy Complications

Covered expenses include charges made in connection with pregnancy complications of a covered female member only. Pregnancy complications mean any condition which requires hospital confinement for medical treatment and:

- If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or
- If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

Birthing Center Facility and Physician's Expenses

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

Covered expenses also include charges made:

- By an operating **physician** for:
  - Delivery;
  - Pre- and post-natal care; and
  - Administration of an anesthetic.
- By a **physician** for administering an anesthetic (other than a local anesthetic).

Important Reminder:
Certain prenatal care services are considered "Preventive Care". Refer to the *Prenatal Care* benefit under the Preventive Care section of this Policy for details.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient **surgery** made by:

- A **physician** or dentist for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital.**

The **surgery** must meet the following requirements:

- The **surgery** can be performed adequately and safely only in a **surgery center** or **hospital**; and
- The **surgery** is not normally performed in a **physician's** or **dentist's** office.

The following outpatient **surgery** expenses are covered:

- Services and supplies provided by the **hospital** or **surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Also refer to Outpatient Preoperative Testing under Diagnostic and Preoperative Testing.

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** as part of a **home health care plan** and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**; or
- Diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live.

Covered expenses include only the following:

- **Skilled nursing services** that:
  - require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license;
  - need to be provided during intermittent visits of four hours or less, with no more than 3 visits in any one day.

  Intermittent visits are:
  - periodic and recurring visits;
  - made by skilled nurses to ensure your proper care, and
  - do not last for more than four hours at a time

  If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits)

of continuous **skilled nursing services**. However, these services must be scheduled within 10 days of discharge.

- Home health aide services that:
  - are provided in conjunction with **skilled nursing services**, that directly support the care.
  - need to be provided during intermittent visits of four hours or less, with no more than 3 visits in any one day.
- Medical social services by a qualified social worker, when provided along with skilled nursing care.

Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse or therapist is one visit.

In figuring the **calendar year** maximum visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day. We only cover charges by a nurse for **medically necessary** private duty nursing care if such care is authorized as part of a written **home health care plan**, coordinated by a **home health care agency**, and covered under the Home Health Care benefit. Any other charges for private duty nursing care are a non-**covered expense.**

Whether or not someone is available to give care does not determine whether the services covered for home health care. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), home health care services will only be covered during times when:

- there is a family member or caregiver present in the home, and
- the family member or caregiver can meet the person's non-skilled needs.

Important Notes:

- This plan covers home short-term physical, speech, or occupational therapy when the above home health care criteria are met. The *Short Term Rehabilitation and Habilitation Therapy Services* section lists the conditions and limitations for certain services.
- Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.
- The plan does *not* cover **custodial care**, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care.

Skilled Nursing Facility

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious **illness** or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;

- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

You must meet the following conditions:

- You are currently receiving inpatient **hospital** care, or inpatient sub-acute care, and
- The **skilled nursing facility** admission will take the place of an admission to, or continued **stay** in, a **hospital** or sub-acute facility; or it will take the place of three or more **skilled nursing services** visits per week at home; and
- There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

Important Notes:

- Refer to the *Schedule of Benefits* for details about **skilled nursing facility** maximums.
- Admissions to a **skilled nursing facility** must be **pre-certified** by **Aetna**. Refer to *Understanding Medical Precertification* for details about **precertification**.
- This plan covers home short-term physical, speech, or occupational therapy when the above skilled nursing facility criteria are met. The *Short Term Rehabilitation and Habilitation Therapy Services* section lists the conditions and limitations for certain services.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day;
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician**;
- Medical supplies;
- **Prescription drugs**;

- Dietary counseling; and
- Psychological counseling.

Covered expenses also include charges made by the providers below if they are not an employee of a **hospice care agency**; and such agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Important Notes:
Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for details about **precertification**.

Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with covered a surgical procedure.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency;
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition;
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles; and
- During a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, to transport a member for inpatient or outpatient **medically necessary** treatment when an **ambulance** is required to safely and adequately transport the member.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available and your condition is unstable, requires medical supervision and rapid transport; and
- Transportation from one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat you when your condition is unstable, requires medical supervision and rapid transport.

Covered expenses include charges to transfer a newly born or adopted child or child placed for adoption, who has been medically diagnosed with a congenital defect or birth abnormality, from their place of birth to the nearest specialized treatment center.

Hormone Replacement Therapy

Covered expenses include charges for outpatient services, and drugs and devices which are lawfully prescribed or ordered and which have been approved by the Food and Drug Administration, incurred in connection with hormone replacement therapy.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- Computerized Axial Tomography (C.A.T.) scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- [Any other outpatient diagnostic imaging service costing over $500.]

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Outpatient Diagnostic Lab Work

Covered expenses include charges for lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Outpatient Diagnostic Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging services) provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Outpatient Preoperative Testing

Prior to a scheduled covered **surgery**, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the **surgery** are covered expenses and the tests are:

- Related to your **surgery**, and the **surgery** takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your **surgery**;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**; and
- Not repeated in or by the **hospital** or **surgery center** where the **surgery** will be performed;

Test results should appear in your medical record kept by the **hospital** or **surgery center** where the **surgery** is performed.

Important Notes:
Refer to the *Schedule of Benefits* for details about any cost-sharing or benefit maximums that apply to outpatient diagnostic testing, lab services and radiological services.

Durable Medical and Surgical Equipment (DME)

Covered **DME** includes those items covered by Medicare unless excluded in the *Medical Benefit Exclusions* section of this Policy.

Covered expenses include:

Charges by a **DME** supplier for the rental of equipment.

In lieu of rental, charges by a **DME** supplier for:

- The initial purchase of **DME** if long term care is planned; and the equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
- Replacement of purchased equipment if:
  - The replacement is needed because of a change in your physical condition; and
  - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of disease or **injury** or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

Hearing Aid Expenses

Covered expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below.

Hearing aid means:

- any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- parts, attachments or accessories.

Covered expenses include the following:

- charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - a **physician** certified as an otolaryngologist or otologist; or
  - an audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- charges for electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam;
- any other related services necessary to access, select and adjust or fit a hearing aid.

Covered expenses for hearing aids will not include per 48 consecutive month period:

- charges for more than one hearing aid per ear; and
- charges in excess of any maximum amount shown on the *Schedule of Benefits*.

Hearing Aids Alternate Treatment Rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:

- Customarily used nationwide for treatment, and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account your physical condition.

You should review the differences in the cost of alternate treatment with your **physician**. Of course, you and your **physician** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

This *Alternate Treatment Rule* provision will not operate to deny benefits as mandated by any applicable state statute or regulation.

Limitations:

No benefits are payable under this benefit for charges incurred for:

- A service or supply which is received while the person is not a covered person under this Plan;
- A replacement of:
  - a hearing aid that is lost, stolen or broken; or
  - a hearing aid installed within the prior 48 month period.
- Replacement parts or repairs for a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss:
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist;
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;
- Any hearing care service or supply which is a **covered expense** in whole or in part under any other part of this Plan;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any hearing exam:
  - required by an employer as a condition of employment; or
  - which an employer is required to provide under a labor agreement; or
  - which is required by any law of government.
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**; and
- Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services

Covered expenses include charges made by a **hospital** for short-term rehabilitation therapy services, as described below, when prescribed by a **physician**. The services have to be performed by:

§ A licensed or certified physical or occupational therapist; or
§ A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A course of outpatient cardiac rehabilitation appropriate for your condition is covered for a cardiac condition that can be changed.

The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician.

Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A course of outpatient pulmonary rehabilitation appropriate for your condition is covered for the treatment of reversible pulmonary disease states.

Unless specifically covered above, *not* covered under this benefit are charges for:

§ Any services unless provided in accordance with a specific treatment plan;
§ Services not performed by a **physician** or under the direct supervision of a **physician**;
§ Services provided by a **physician** or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner; or

Short-Term Rehabilitation and Habilitation Therapy Services

Covered expenses include charges for short-term rehabilitation and habilitation therapy services, as described below, when prescribed by a **physician** up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

§ A licensed or certified physical, occupational or speech therapist;
§ A **hospital**, **skilled nursing facility**, or **hospice facility**;
§ A **home health care agency**; or
§ A **physician**.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation and Habilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation and habilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Policy.

§ Physical therapy is covered provided that the therapy is expected to:
  - significantly improve, develop or restore physical functions lost; or
  - improves any impaired function;

  as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training.
§ Occupational therapy, (except for vocational rehabilitation or employment counseling), is covered provided that the therapy is expected to:
  - significantly improve, develop or restore physical functions lost as a result of an acute **illness**, **injury** or surgical procedure; or
  - improve an impaired function as a result of an acute **illness**, **injury** or surgical procedure; or
  - to relearn skills to significantly improve independence in the activities of daily living.

  Occupational therapy does not include educational training.
§ Speech therapy is covered provided that the therapy is expected to:
  - restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or
  - improve delays in speech function development as a result of a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
§ Cognitive therapy associated with physical rehabilitation or habilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

§ Details the treatment, and specifies frequency and duration; and
§ Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
§ Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

§ Educational services for Down's Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
§ Any services unless provided in accordance with a specific treatment plan;
§ Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;
§ Services not performed by a **physician** or under the direct supervision of a **physician**;
§ Treatment covered as part of the Chiropractic Treatment. This applies whether or not benefits have been paid under that section;
§ Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
§ Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Chiropractic Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**;
- For treatment of scoliosis;
- For fracture care; or
- For **surgery**. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Specialized Care

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is **surgery** and reconstruction on a healthy breast to make it symmetrical with the reconstructed breast and prosthesis and physical therapy to treat complications for all stages of mastectomy, including lymphedema.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

§ Surgery needed to improve a significant functional impairment of a body part.
§ Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
§ Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

§ Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  § the defect results in severe facial disfigurement, or
  § the defect results in significant functional impairment and the surgery is needed to improve function

Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria;
  - The drug, device, treatment, or procedure to be investigated has been granted investigational new drug (IND) or group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

You are subject to all of the terms, conditions, provisions, limitations and exclusions of this plan including, but not limited to, **precertification** requirements.

Outpatient Therapies

Chemotherapy Benefits

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in their office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are needed for your course of treatment. Charges for the following outpatient infusion therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Coverage for inpatient infusion therapy is provided under the Inpatient **Hospital** and **Skilled Nursing Facility** Benefits sections of this Policy.

Benefits payable for services related to infusion therapy will not count toward any applicable **home health care** maximums.

Clinical Trial Expenses

This Plan will pay for the **necessary** and routine patient care physician and facility charges incurred by a Policyholder or covered dependent who is enrolled in a Phase I, Phase II, Phase III or Phase IV study or Clinical Trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome. A "clinical trial" means a patient research study that is designed to evaluate a new medical or drug treatment. Such proposed treatment:

- must be for cancer or chronic fatigue syndrome;
- for Phase I clinical trial or study for the treatment of cancer, must be provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer;
- for Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, must be provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner; and
- must not be less appropriate for that patient than available alternative medical treatment; and
- must have clinical data that the medical treatment provided in the clinical trial or study will be at least as effective for that patient as any other medical treatment.

The clinical trial must meet the following criteria:

- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA), the Department of Defense, the Department of Veterans Affairs, or other similar national cooperative body; and
- must be provided in the state of Nevada.
- The Policyholder or covered dependent must have signed, prior to participation in the clinical trial, a statement of consent indicating that he or she has been informed of:
    - the procedure to be undertaken;
    - alternative methods of treatment; and
    - the risks associated with participation in the clinical trial, including, without limitation, the general nature and extent of such risk.

Unless the following medical treatment is provided by the sponsor of the clinical trial or study free of charge to the covered person, charges for Covered Medical Expenses incurred by a Policyholder or covered dependent for:

- the initial consultation to determine whether the covered person is eligible to participate in the clinical trial or study;
- any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the covered person;
- health care services for the appropriate monitoring of the covered person during a Phase II, Phase III or Phase IV clinical trial or study;
- the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care service would otherwise be covered under the policy of health insurance;
- the cost of any routine health care services that would otherwise be covered under the policy of health insurance for an insured participating in a Phase I clinical trial or study; and
- health care services for the appropriate monitoring of the covered person during a Phase I clinical trial or study and which are not directly related to the clinical trial or study;

are payable on the same basis as any disease or illness covered under this Plan.

Any care provided in the clinical trial must be for services that are considered Covered Medical Expenses under this Plan. They must be consistent with all of the terms and conditions of this Plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Policyholders and covered dependents are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to: precertification and referral requirements.

Not covered are charges for:

- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry;
- any expenses for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device;
- any expenses for health care services that are specifically excluded from coverage under this Plan, regardless of whether such services are provided under the clinical trial or study;
- costs of data collection and analysis that is not directly related to the clinical management of the Policyholder or covered dependent;
- any expenses for the management of research;
- any expenses related to participation in the clinical trial, including travel, housing, and other expenses;
- any expenses incurred by a person accompanying the Policyholder or covered dependent;
- services and supplies provided free of charge by the trial sponsor to the Policyholder or covered dependent; and
- any injury to the Policyholder or dependent caused by:
  any medical treatment provided in connection with participation in a clinical trial or study as described under this benefit;

an act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment in connection with participation in a clinical trial or study as described under this benefit; and

- any adverse or unanticipated outcome arising out of participation in a clinical trial or study as described under this benefit.

Diabetes Benefits

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

Services and Supplies:

- Foot care to minimize the risk of infection;
- Insulin preparations;
- Diabetic needles and syringes;
- Injection aids for the blind;
- Diabetic test agents;
- Lancets/lancing devices;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons; and
- Glucagon emergency kits.

Equipment:

- External insulin pumps; and
- Blood glucose monitors without special features unless required due to blindness.

Self-management Training:

- The training and education provided to you after you are initially diagnosed with diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in your symptoms or condition which requires modification of your program of self-management of diabetes; and
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility Expenses

To be an eligible covered female for benefits you must be covered under this Policy as a subscriber, or be a covered dependent who is the subscriber's legal spouse,

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility**, has been recognized and diagnosed as **infertility**, by a gynecologist; network **infertility specialist**, or your **physician**, and it has been documented in your medical records.
- The procedures are done; while not confined in a **hospital**; or any other facility; as an inpatient.
- Your FSH levels are less than; 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Policy.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above the following comprehensive infertility services expenses are payable when provided by an **infertility specialist** upon **precertification** by **Aetna**, subject to the all the exclusions and limitations of this Policy*:*

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown on the *Schedule of Benefits* and a maximum of 6 cycles per lifetime; (where lifetime is defined to include services provided or administered by **Aetna** or any affiliated company of **Aetna** or any other health benefits plan or where no plan coverage was provided; and
- Intrauterine insemination is subject to the maximum benefit, if any, shown on the *Schedule of Benefits* and a maximum of 6 cycles per lifetime; (where lifetime is defined to include services provided or administered by **Aetna** or any affiliated company of **Aetna** or any other health benefits plan or where no plan coverage was provided.

Important Note:
Treatment received without **precertification** will not be covered. You will be responsible for full payment of the services.

Refer to the *Schedule of Benefits* for details about the maximums that apply to **infertility** services. The **lifetime maximums** that apply to **infertility** services apply differently than other **lifetime maximums** under this Plan.

Bariatric Surgery

Covered expenses for the treatment of **morbid obesity** include one bariatric surgical procedure, per lifetime, including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Policy.

Non-Prescription Enteral Formula Expense

Covered expenses include charges for enteral formulas and special food products for use at home which are prescribed or ordered by a **physician** as medically necessary for the treatment of deficient

metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.

Covered expenses will also include food products modified to be low protein.

For this benefit, "inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person. "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Autism Spectrum Disorders

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment, (including behavioral therapy), of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan.

Coverage includes Applied Behavioral Analysis. Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Coverage for Applied Behavioral Analysis is subject to the maximums shown in the *Schedule of Benefits*.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
-
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Treatment of Temporomandibular Joint Dysfunction

Covered expenses include charges made by a **physician, hospital** or **surgery center** for the diagnosis, and **medically necessary** surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ). Coverage of TMJ does not include methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

Transplant Services

Covered expenses include charges incurred during a Transplant Occurrence. Once it has been determined that you or one of your dependents may require an organ transplant, you or your **physician** should call **Aetna** to obtain the necessary **precertification**. Organ means solid organ; stem cell; bone marrow; and tissue.

Network of Transplant Specialist Facilities

Benefits may vary if an **Institute of Excellence™ (IOE)** facility or non-**IOE** or **out-of-network provider** is used. Through the **IOE** network, you will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The network level of benefits is paid only for a treatment received at a facility designated by this plan as an **IOE** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered in-network care expenses.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network services and supplies**, even if the facility is a network facility or **IOE** facility for other types of services.

This plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent that it is not covered by another plan or program.
- Related supplies and services provided by the **IOE** facility during the transplant process. These services and supplies may include: physical, speech, and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Transportation, lodging and meal expense up to $200 a day, with a maximum of $10,000 per Transplant Occurrence.

Covered transplant expenses are typically incurred during the 4 phases of transplant care described below. Expenses incurred for 1 transplant during these 4 phases of care will be considered 1 Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The 4 phases of 1 Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogeneic Blood/Bone Marrow transplant (when not part of a tandem transplant).
- Allogeneic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- [• Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not a covered person;
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.]

Important Notes:

- To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for details about **precertification**

- Refer to the *Schedule of Benefits* for details about transplant expense maximums.
- Transplant expenses are subject to a separate payment limit. Refer to the *Schedule of Benefits*.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for **surgery** needed to:

- Treat a fracture, dislocation, or wound;
- Cut out cysts, tumors, or other diseased tissues;
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth;

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut;

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the **calendar year** of the **accident** or in the next **calendar year**.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury.**

Treatment of Mental Disorders

This Plan pays charges incurred for the treatment of **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- Such treatment is for a condition that can favorably be changed.

Important Notes:
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Benefit Exclusions* section for more information.

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **mental disorders** as follows:

- **Inpatient room and board** at the **semi-private room rate,** and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**. Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting.

- Outpatient treatment received while not confined as an inpatient in a **hospital** or **psychiatric hospital** or as part of **partial hospitalization treatment** as described below.

  Partial hospitalization treatment (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment. **Partial hospitalization treatment** will only be covered if:
  - you would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
  - the severity of your condition requires services provided in a **partial hospitalization treatment** setting.

Benefits are payable in the same way as those for any other disease.

Important Notes:
Inpatient and certain outpatient treatments must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for more information about **precertification**.

Treatment of Substance Abuse

This Plan pays charges incurred for the treatment of **substance abuse** by **behavioral health providers** and medical addictionologists. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- Such treatment is for a condition that can favorably be changed.

Important Note:
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Benefit Exclusions* section for more information.

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **substance abuse** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting. Treatment in a **hospital** is covered only when the **hospital** does not have a separate **substance abuse** section or unit, or is for treatment of medical complications of **substance abuse**.

  As used here, "medical complications" include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital** or **psychiatric hospital** or as part of **partial hospitalization treatment** as described below.

Partial hospitalization treatment (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment. **Partial hospitalization treatment** will only be covered if:

- you would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
- the severity of your condition requires services provided in a **partial hospitalization treatment** setting.

Benefits are payable in the same way as those for any other disease.

Important Notes:
Inpatient and certain outpatient treatments must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for more information about **precertification**.

Pediatric Dental Benefits

Pediatric Dental Services

Covered expenses include charges made by a **dental provider,** who is a **network provider,** for the dental services listed in the Pediatric Dental Care Schedule below and provided to covered persons through age 18].

The plan does not pay a benefit for all dental care expenses that you incur.

Important Reminder:

Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

About the PPO Dental Expense Insurance Plan

The plan is a Preferred Provider Organization (PPO) Dental Expense Insurance Plan that covers a limited range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more out of your own pocket when you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the Plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice Is Yours

You have a choice each time you need dental care:

Using Network Providers

- You will receive the Plan's higher level of benefits when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge.** Your **coinsurance** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles, coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible, copayment, coinsurance**, or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Contact [Member Services] by [logging onto the Aetna website www.aetna.com, or] calling the toll-free number on the back of your ID card if you have questions regarding your statement.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract or a **network provider** may limit the number of patients accepted in a practice.

Using Out-of-Network Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

Out-of-network providers have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Deductibles** and **coinsurance** are usually higher when you utilize **out-of network providers.** Except for emergency services, **Aetna** will only pay up to the **recognized charge**.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).

Pediatric Dental Care Schedule

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition;

then the charge will be considered to have been made for a service in the list that **Aetna** determines would have produced a professionally acceptable result.

The Pediatric Dental Care Schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Diagnostic and Preventive Care
- Basic Restorative Care
- Major Restorative Care
- Orthodontic Treatment Care

These covered services and supplies are grouped as Type A, Type B, Type C and Orthodontic Care.

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the network level of benefits even if services and supplies are not provided by a **network provider**. For additional information, please refer later in this amendment to the *In Case of a Dental Emergency* section.

Type A Expenses: Diagnostic and Preventive Care

Visits and Images

- Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every 12 months)
- Problem-focused examination (limited to 6 visits every 12 months)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride, (limited to 2 treatments per year
- Flouride varnish (limited to 2 treatments per year)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only)
- Preventive resin restoration (limited to one application every 3 years for permanent molars only)
- Oral hygiene instructions (limited to 2 treatments per year)
- Bitewing images (limited to 2 sets per year)
- Periapical images
- Complete image series, including bitewings (limited to 1 every 11 months)
- Panoramic film (limited to 1 set every 3 years)
- Vertical bitewing images (limited to 2 sets every 12 months)

Space Maintainers

- Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Recement or removal of space maintainers

Type B Expenses: Basic Restorative Care

Visits and Images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit
- Office visit for observation
- Consultation by other than the treating provider (limited to 1 per year)
- Hospital call (when medically necessary)
- Dental house (call when medically necessary)

Images and Pathology

-
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Occulusal image
- Biopsy and accession of tissue examination of oral tissue
- Theraputic drug injection
- Theraputic parental drugs

Oral Surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Surgical removal of residual tooth roots
- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Transplantation of tooth or tooth bud
  - Tooth reimplantation
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Frenuloplasty
  - Excision of pericoronal gingiva
  - Suture of soft tissue injury
  - Biopsy of oral tissue (hard and soft tissue)

Exfoliative cytological sample collection

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to 4 separate quadrants every 12 months)
- Root planing and scaling – 1 to 3 teeth per quadrant (limited to 4 separate quadrants every 12 months)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Periodontal maintenance procedures following active therapy (limited to 1 every 3 months)
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Apexification/recalcification
- Apicoectomy
- Retrograde filing
- Root amputation
- Endodontic endosseous implant
- Hemisection (including any root removal)
- Root canal therapy including **medically necessary** images:
  Anterior
  Bicuspid
- Retreatment of root canal therapy including **medically necessary** images:
  Anterior
  Bicuspid

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)

- Amalgam restorations
- Protective restorations
- Occlusal adjustments
- Resin-based composite restorations (other than for molars)
- Pins
  Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  Prefabricated stainless steel
  Prefabricated resin crown (excluding temporary crowns)
- Recementation
  Inlay
  Crown
  Bridge
  Fixed partial denture
  Cast or prefabricated post

Type C Expenses: Major Restorative Care

Oral Surgery

- Surgical removal of impacted teeth
  Removal of tooth (partially bony)
  Removal of tooth (completely bony)

Removal of impacted tooth with surgical complications

-

Periodontics

- Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
- Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
- Soft tissue graft procedures
- Full mouth debridement
- Distal or proximal wedge procedure

Endodontics

- Molar root canal therapy including **medically necessary** images
- Retreatment of molar root canal therapy including **medically necessary** images

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5years.) See the *Replacement Rule* provision appearing later in this amendment).
- Inlays/Onlays
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Titanium
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
- Post and core
- Core build-up

Prosthodontics

- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. (See the *Tooth Missing But Not Replaced* Rule later in this amendment.)
- Replacement of existing bridges or dentures is limited to 1 every 5 years. (See the *Replacement Rule* provision appearing later in this amendment.)
- Bridge Abutments (See Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal

Resin with base metal
- Removable Bridge (unilateral)
  One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  Complete upper denture
  Complete lower denture
  Immediate upper denture
  Immediate lower denture
  Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  Pediatric fixed partial denture
  Stress breakers
  Interim partial denture (stayplate), anterior only
  Office reline
  Laboratory reline
  Precision attachments
  Special tissue conditioning, per denture
  Rebase, per denture
    Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
  Broken dentures, no teeth involved
  Repair cast framework
  Replacing missing or broken teeth, each tooth
  Adding teeth to existing partial denture
    Each tooth
    Each clasp
- Repairs: crowns, bridges and fixed partial dentures
- Fixed partial denture sectioning
- Occlusal analysis
- Occlusal guard

General Anesthesia, Intravenous Sedation and Non-intravenous Sedation
- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
- Local anesthesia (not in conjunction with surgical procedures)
- Trigeminal division block anesthesia

Orthodontics
Medically necessary comprehensive orthodontic treatment
- Replacement of retainer (limit one per lifetime)

Getting an Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note:

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $300. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting images and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See the *Alternate Treatment Rule* later in this amendment for more information on alternate dental procedures.)

What Is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

In Case of a Dental Emergency

If you need dental care for the palliative treatment (e.g., pain relieving, stabilizing) of a **dental emergency**, you are covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Follow the guidelines below when you believe you have a **dental emergency**.

If you have a **dental emergency**, call your dental **network provider**. If you cannot reach your dental **network provider** or are away from home, you may get treatment from any **dentist**. You should call [Member Services] for help in finding a **dentist**. The care must be for the temporary relief of the **dental emergency** until you can be seen by your dental **network provider**.

What does the Plan pay when you go to an out-of-network provider for a Dental Emergency?

The plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a **network provider**. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given by an **out-of-network provider**.

The plan pays a benefit up to the dental emergency maximum for care provided by an **out-of-network provider.**

All follow-up care should be provided by your dental **network provider**. Additional dental care to treat your **dental emergency** will be covered at the appropriate **coinsurance** level depending upon where you go for service.

Rules and Limits That Apply to the Dental Benefits

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Waiting Period

The plan has a waiting period for **orthodontic treatment** as follows

- **Orthodontic treatment**: Your coverage will take effect after 24 months of continuous coverage under the Plan].

Orthodontic Treatment Rule

Orthodontic treatment is covered when it is **medically necessary** for a covered person under the age of 19 with a fully erupted set of permanent teeth and a severe, dysfunctional, handicapping condition such as:

(A) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

(B) The following craniofacial anomalies:
- Hemifacial microsomia;
- Craniosynostosis syndromes;
- Cleidocranial dental dysplasia;
- Arthrogryposis; or
- Marfan syndrome

(C) Anomalies of facial bones and/or oral structures

(D) Facial trauma resulting in functional difficulties

Reimbursable orthodontic services include:
- pre-orthodontic treatment visit
- comprehensive orthodontic treatment
- orthodontic retention (removal of appliances, construction and placement of retainers(s)

This benefit does not cover charges for the following:
- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to **Aetna** that:
- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:
- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth; and

- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within [30-120 days] after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Pediatric Dental Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary**. Charges made for the following are not covered except to the extent listed under the *What the Medical Benefit Covers* section of the Policy or by amendment attached to the Policy. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the following exclusions that apply to medical benefits.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Medical Benefit Covers* section of the Policy.

- Any non-emergency charges for **covered expenses** incurred outside of the United States.

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in the Policy.

- Any instruction for diet, plaque control and oral hygiene.

- Charges submitted for services:
  - By an unlicensed **hospital**, **physician** or other provider; or
  - By a licensed **hospital**, **physician** or other provider that are not within the scope of the provider's license.

- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

- **Cosmetic** services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Medical Benefit Covers* section of the Policy. Facings on molar crowns and pontics will always be considered **cosmetic**.

- Court ordered services, including those required as a condition of parole or release.

- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.

- Dental Examinations that are:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service.

- Dental implants, braces except to the extent coverage is specifically provided in the *What the Medical Benefit Covers* section of the Policy, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

- Dental services and supplies that are covered in whole or in part under any other part of this plan.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

- Except as covered in the *What the Medical Benefit Covers* section of the Policy, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- **Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Medical Benefit Covers* section of the Policy.

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **medically necessary** covered service or supply.

- Medicare: Payment for that portion of the charge for which Medicare is the primary payer.

- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a **physician's** practice;
  - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:

    Care in charitable institutions;

    Care for conditions related to current or previous military service;

    Care while in the custody of a governmental authority;

    Any care a public **hospital** or other facility is required to provide; or

    Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

- Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

- **Orthodontic treatment** except as covered in this amendment and in the *What the Medical Benefit Covers* section of the Policy.

- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

- Prescribed drugs; pre-medication; or analgesia.

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

- Replacement of teeth beyond the normal complement of 32.

- Routine dental exams and other preventive services and supplies, except as specifically provided in this amendment and in the *What the Medical Benefit Covers* section of the Policy.

- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Services rendered before the effective date or after the termination of coverage.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Surgical removal of impacted wisdom teeth only for orthodontic reasons.

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.

- Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Medical Benefit Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dental provider**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Medical Benefit Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Medical Benefit Covers* section or by amendment attached to this Policy.

You have medical and **prescription drug** insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional limitations and exclusions apply to **prescription drug** coverage. Those additional limitations and exclusions are listed separately under the *Pharmacy Benefit Exclusions* section of this Policy.

Exclusions and Limitations

- [Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Medical Benefit Covers* section.

- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

- Air or Water **Ambulance** (except as provided in the *What the Medical Benefit Covers* section):

  - If an **ambulance** service is not required by your physical condition; or
  - If the type of **ambulance** service provided is not required for your physical condition; or
  - By any form of transportation other than a professional **ambulance** service.

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this Policy.

- Any non-emergency charges for **covered expenses** incurred outside of the United States.

- Artificial organs: Any device intended to perform the function of a body organ.

- Behavioral health services that are not primarily aimed at treatment of **illness**, **injury**, restoration of physiological functions or that do not have a physiological or organic basis.

- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

- Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge** or an **out-of-network provider** in excess of the **recognized charge**.

- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.]

- [Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

- Conditions caused by an act of war, including those caused by the inadvertent release of nuclear energy when government funds are available for treatment of **illness** or **injury** arising from such release of nuclear energy.

- **Cosmetic** services and plastic **surgery (**unless specifically described in the *What the Medical Benefit Covers* Section), any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter the shape or appearance of the body, whether or not for psychological or emotional reasons, including:
  - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, **cosmetic** eyelid **surgery** and other **surgical procedures**;
  - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
  - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
  - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant will be covered when **medically necessary**;
  - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
  - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
  - Surgery to correct Gynecomastia;
  - Breast augmentation; and
  - Otoplasty.

- Counseling: services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

- Court ordered services, including those required as a condition of parole or release.

- **Custodial care.**

- Dental services except for what is specifically covered under the *What the Medical Plan Covers* section.

- Disposable outpatient supplies (unless specifically described in the *What the Medical Benefit Covers* Section.): Any outpatient disposable supply or device, including but not limited to sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.]

- [Drugs, medications and supplies which include **(**unless specifically described in the *What the Medical Benefit Covers* Section):
  - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
  - Services related to the dispensing, injection or application of a drug;
  - A **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
  - Immunizations related to travel or work;
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
  - Drugs related to the treatment of non-**covered expenses**;
  - Performance enhancing steroids;
  - Implantable drugs and associated devices;
  - Injectable drugs if an alternative oral drug is available, unless medically necessary;
  - Any expenses for **prescription drugs**, and supplies covered under the Pharmacy benefit will not be covered under this medical expense plan. **Prescription drug** exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
  - Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

- Educational services:
  - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause, except as described in the *What the Medical Benefit Covers* Section; and
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

- Examinations.
  Any health examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses; and
  - required to travel, attend a school, camp, or sporting event, or participate in a sport or other recreational activity.

  Also, any special medical reports not directly related to treatment except when provided as part of a covered service.

- **Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Medical Benefit Covers* section.]

- [Facility charges for care services or supplies provided in:
  - rest homes;
  - assisted living facilities;
  - similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
  - health resorts;
  - spas, sanitariums; or
  - infirmaries at schools, colleges or camps.

- Food and nutritional items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This limitation will not apply to formulas and special modified food products as specifically stated in this Policy.

- Foot care: Except as specifically covered for medical necessity due to illness, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

- Genetics: except as described in the *What the Medical Benefit Covers* section , the plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

- Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including **surgical procedure**s, devices to stimulate growth, and growth hormones.

- Hearing: Related services and supplies, except as described in the *What the Medical Benefit Covers* section.

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:
  - Bathroom equipment such as bathtub seats, benches, rails, and lifts;
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
  - Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables, and reclining chairs;
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
  - Other additions or alternations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;]

[- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alternations to any vehicle or transportation device.

- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

- **Home Health Care.** Unless specified in *What the Medical Benefit Covers* section, *not* covered under this policy are charges for:
  - Services or supplies that are not a part of the **home health care plan**;
  - Services of a person who usually lives with you, or who is a member of your, or your spouse's or your domestic partner's family;
  - Services for infusion therapy;
  - Transportation;
  - Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
  - Services that are **custodial care**.

- Home uterine activity monitoring.

- **Hospice**. Unless specified in *What the Medical Benefit Covers*, not covered under this benefit are charges for:
  - Daily **room and board** charges over the **semi-private room rate**;
  - Bereavement counseling;
  - Funeral arrangements;
  - Pastoral counseling;
  - Financial or legal counseling. This includes estate planning and the drafting of a will;
  - Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.]

- **[Infertility**: except as specifically described in the *What the Medical Benefit Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
  - Drugs related to the treatment of non-**covered expenses**;
  - Injectable **infertility** medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
  - Artificial Insemination;
  - Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not **infertile** as defined by the plan;
  - **Infertility** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
  - Procedures, services and supplies to reverse voluntary sterilization;
  - **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
  - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
  - Home ovulation prediction kits or home pregnancy tests; and
  - Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
  - ovulation induction and intrauterine insemination services if you are not fertile.

- **Maintenance care**: Care made up of services and supplies that are furnished mainly to maintain, rather than to improve, a level of physical or mental function; and provide a surrounding free from exposures that can worsen the person's physical or mental condition.

- Medicare: Payment for that portion of the charge for which Medicare is the primary payer.]

- [Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a **physician's** practice;
  - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    Care in charitable institutions;

    Care for conditions related to current or previous military service;

    Care while in the custody of a governmental authority;

    Any care a public **hospital** or other facility is required to provide; or

    Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

- Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drug**s and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Oral and maxillofacial treatment (mouth, jaws and teeth) except as described in the *What the Medical Benefit Covers* section.]

- [**Outpatient Cognitive Therapy, Physical Therapy, and Occupational Therapy Rehabilitation** . Unless specified in *What the Medical Benefit Covers*, not covered under this policy are charges for:
  - [- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders including Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;]
  - Any services unless provided in accordance with a specific treatment plan;
  - Services for the treatment of delays in development, including speech development, unless resulting from: **illness**; **injury**; or congenital defect;
  - Services provided during a **stay** in a **hospital**, **skilled nursing facility** or **hospice facility** except as stated in *What the Medical Benefit Covers*;
  - Services provided by a **home health care agency**;
  - Services not performed by a **physician** or under the direct supervision of a **physician**;
  - Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
  - Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

- Personal comfort and convenience items. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

- Private duty nursing services during your **stay** in a **hospital**, and outpatient private duty nursing services. **Skilled nursing services** are covered as specifically described in the *What the Medical Benefit Covers* section in accordance with a **home health care** plan approved by **Aetna**.

- Prosthetics or prosthetic devices unless specifically covered under *What the Medical Benefit Covers* section. The plan will not cover expenses and charges for, or expenses related to:
  - Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace;
  - Trusses, corsets, and other support items; or
  - Any additional item or supply listed in the *Medical Benefit Exclusions* section.

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Medical Benefit Covers* section.]

- [Sex change: Any treatment, drug, service or supply for changing sex or sexual characteristics, including but not limited to:

  - **Surgical procedure**s to alter the appearance or function of the body;
  - Hormones and hormone therapy;
  - Prosthetic devices; and
  - Medical or psychological counseling.

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

- Services of a resident **physician** or intern rendered in that capacity.

- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

- Services rendered before the effective date or after the termination of coverage.

- Sexual dysfunction/enhancement: Any treatment, **prescription drug**, service or supply to treat erectile dysfunction, impotence, sexual dysfunction or inadequacy, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

- **Skilled Nursing Facility.** Unless specified in *What the Medical Benefit Covers*, not covered under this policy for **Skilled Nursing Facility** benefits are charges for:
  - Treatment of:
    Substance abuse;
    Senility;
    Mental retardation; or
    Any other **mental disorder**.
  - Daily **room and board** charges over the **semi-private room rate**.

- Services that are not covered under this Policy, including services and supplies provided in connection with treatment or care that is not covered under the plan.

- Speech therapy for treatment of delays in speech development, except as specifically provided in *What the Medical Benefit Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

  - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
  - Drugs or preparations to enhance strength, performance, or endurance; and
  - Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance enhancing drugs or preparations.]

[Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Down syndrome and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

- Therapies and tests: Any of the following treatments or procedures including but not limited to:
  - Aromatherapy;
  - Bio-feedback and bioenergetic therapy;
  - Carbon dioxide therapy;
  - Chelation therapy (except for heavy metal poisoning);
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered **surgery**;
  - Massage therapy;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Sensory or auditory integration therapy;
  - Sleep therapy;
  - Thermograms and thermography.

- Tobacco use: Except as described in the *What the Medical Benefit Covers section*, any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

- Transplant: The transplant coverage does not include charges for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when the recipient is not a covered person;
  - Home infusion therapy after the transplant occurrence;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
  - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**; and
  - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.]

- [Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Medical Benefit Covers section* or the *Schedule of Benefits*.

- Unauthorized services, including any service obtained by or on behalf of a covered person without **Precertification** by **Aetna** when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

- Vision: Vision-related services and supplies, except as described in the *What the Medical Benefit Covers* section.

  In addition, the plan does not cover:

  - Special supplies such as non-**prescription** sunglasses;
  - Vision service or supply which does not meet professionally accepted standards;
  - Special vision procedures, such as orthoptics or vision training;
  - Eye exams during your **stay** in a **hospital** or other facility for health care;
  - Eye exams for contact lenses or their fitting;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Acuity tests;
  - Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures;
  - Services to treat errors of refraction.

- Voluntary termination of pregnancy, including related services.

- Weight: Except as described in the *What the Medical Benefit Covers* section, any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, including but not limited to:
  - Liposuction;
    surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis, or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

- Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational **illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.]

Your Pharmacy Benefits

This section describes which **pharmacy** expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. The plan does not cover all **prescription drugs**, medications and supplies. Refer to the *Medical Benefit Exclusions* and *Pharmacy Benefit Exclusions* sections of this Policy.

This plan covers certain **prescription drugs** in accordance with the plan that you elected and the **preferred drug guide (formulary)**. This plan does not cover all **prescription drugs**.

This plan provides access to **covered expenses** through a network of pharmacies**,** vendors or suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you. You also have the choice to access State licensed **pharmacies** outside the network for **covered expenses**.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between network and out-of network benefits. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug.**

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you, and any per prescription or refill dollar maximums that may apply. To better understand the choices that you have with your plan, please carefully review the following information.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract. You may search online for the most current list of **network pharmacies** in your area by using [DocFind®], **Aetna**'s online provider **directory** at [www.aetna.com] or by referring to the *Contact Us* section. If you cannot locate a **network pharmacy** in your area call Member Services at the toll free number on the back of your ID card.

Accessing Network Pharmacies and Benefits

You must present your ID card to the **network pharmacy** when you get a **prescription** filled to be eligible for the network level of benefits. The **network pharmacy** will process your claim online. You will pay any **deductible**, **copayment** or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in the Schedule of Benefits.

You must satisfy any applicable **deductible(s)** before the plan will start to pay benefits. Then you will be responsible for the **copayment** or **coinsurance** for each **prescription** or refill as specified in the *Schedule of Benefits*. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing. The **deductible** and **copayment** or **coinsurance** are payable directly to the **network pharmacy** at the time the **prescription** is dispensed. You will be responsible for your **deductible**, **copayment** and **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.

Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the **calendar year**. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* for information on what expenses do not apply to the limit.

The plan will pay for **covered expenses**, up to the maximums shown in the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximums.

Accessing Out-of-Network Pharmacy Benefits

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**.

You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network pharmacy**. **Aetna** will reimburse you for a **covered expense** less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in the Schedule of Benefits.

You must satisfy any applicable **deductible(s)** before the plan will start to pay benefits. Then you will be responsible for **copayment** or **coinsurance** for covered **prescription** drugs. You will be responsible for any covered expense that you incur for each **prescription** drug or refill as specified in the *Schedule of Benefits*.

Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the **calendar year**. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* for information on what expenses do not apply to the limit. Refer to the *Schedule of Benefits* for the specific **maximum out-of-pocket limit** amounts that apply to your plan.

The plan will pay for **covered expenses**, up to the maximums shown in the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximums.

Emergency Prescriptions

When you need a **prescription** filled in an **emergency care** situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any retail **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy**, you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for network benefits. This network level of coverage for **prescription drugs** obtained from an **out-of-network pharmacy** is limited to those obtained in connection with **emergency care** and out-of-area **urgent care** services.

What the Pharmacy Benefit Covers

Your Prescription Drug Plan Coverage

Prescription Drug Benefit

The plan covers charges for outpatient **prescription drugs** for the treatment of an **illness** or **injury**, including drugs and devices for contraception and for hormone replacement therapy, subject to the

Medical Benefit and *Pharmacy Benefit Exclusions* sections of this Policy. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

This plan covers only certain **prescription drugs** in accordance with the type of plan you elected and the **preferred drug guide (formulary)**. This plan does not cover all prescription drugs.

You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Prescription drugs that are not listed on the **preferred drug guide (formulary)** are excluded from coverage unless a medical exception is approved by **Aetna**. Refer to the *Medical Exceptions* described below for details. If it is **medically necessary** for you to use a **prescription drug not** on the **preferred drug guide (formulary)**, you or your **prescriber** must request coverage as a medical exception.

Your **prescription drug** benefit may be subject to pharmacy management programs including, but not limited to **precertification**, **step therapy,** quantity limits and drug utilization review. Refer to *Understanding Pharmacy Precertification* for further information.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a retail **pharmacy**. Each **prescription** is limited to a maximum supply when filled at a retail **pharmacy** up to the maximums shown in the *Schedule of Benefits***.**

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **mail order pharmacy** that is a **network pharmacy**. Each **prescription** is limited to a maximum [31-91 day] supply when filled at a **mail order pharmacy** that is a **network pharmacy. Prescriptions** more than a [31-91 day] supply are not eligible for coverage when dispensed by a **mail order pharmacy** that is a **network pharmacy**.

The plan will not cover outpatient **prescription drugs** received through a **mail order pharmacy** that is an **out-of-network pharmacy.**

Specialty Care Prescription Drug Benefits

Network Benefits

Specialty care prescription drugs (specialty care drugs) are covered at the network level of benefits only when dispensed through a retail **network pharmacy** or a **specialty network pharmacy**. Refer to **Aetna's** website, [www.aetna.com] to review the list of covered **specialty care prescription drugs.**

You are required to obtain **specialty care prescription drugs** at a **specialty network pharmacy** for all **prescription drug** refills after the initial fill.

Out-of-Network Benefits

Specialty care prescription drugs (specialty care drugs) are covered at the out-of-network level of benefits when obtained from an **out-of-network pharmacy**.

Additional Covered Pharmacy Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses**. Some of these **covered expenses** may be covered under your pharmacy benefit while others are covered under your medical benefit.

Off-Label Use

FDA-approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s) subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information);
  - Thomson Micromedex DrugDex System (DrugDex);
  - Clinical Pharmacology (Gold Standard, Inc.); or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial. Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - the dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above; or
  - the dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Coverage of off-label use of these drugs may, in Aetna's discretion, be subject to **precertification**, **step therapy** or other requirements or limitations.

Diabetic Supplies

The following diabetic supplies are covered upon **prescription** by a **physician**:

- Diabetic needles and syringes;
- Test strips for glucose monitoring or visual reading;
- Diabetic test agents;
- Lancets/lancing devices;
- Alcohol swabs;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Injectable glucagon which included Glucagon emergency kits;
- Insulin preparations.

Please see additional Diabetic Equipment, Supplies and Education covered benefits in the *What the Medical Benefit Covers* section.

Contraceptives

Covered expenses include charges made by a **pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female contraceptives that are **prescription drugs** including emergency contraceptives that are included on the **preferred drug list (formulary)**.
- Female contraceptive devices.

Benefits are payable under your medical or **pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are payable under your medical plan when charges are made by a **physician** to insert or remove a **prescription drug** or device.

Refer to your *Schedule of Benefits* for the *Female Contraceptives - Copayment and Deductible Waiver* provision for more information.

Understanding Pharmacy Precertification

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and modification by **Aetna**. An updated copy of the list of drugs requiring **precertification** shall be available upon request or can be found in the **preferred drug guide** (**formulary**) available online at [www.aetna.com].

Failure to **pre-certify** will result in reduction of benefits or denial of coverage, (see your *Schedule of Benefits*), so be sure to ask your **prescriber** or pharmacist if the drug being considered requires **precertification**.

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network provider,** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network provider**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on the back of your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **pre-certified**.

If **precertification** is denied, **Aetna** will notify you how the decision can be appealed.

Step Therapy

Step-therapy is another form of **precertification**. With **step-therapy**, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the **prescriber** obtains a medical exception.

Lists of the **step-therapy** drugs and prerequisite drugs are included in the **preferred drug guide (formulary)** available upon request or online at [www.aetna.com]. The list of step therapy drugs are subject to change by **Aetna**.

Medical Exceptions

Your **prescriber** may seek a medical exception to obtain coverage for drugs not listed on the **preferred drug guide (formulary)** or for which coverage is denied through **precertification**. The **prescriber** must submit such exception requests to **Aetna**. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons. If approved by **Aetna**, you will receive the Non-Preferred benefit level as shown in your *Schedule of Benefits.*

Pharmacy Benefit Limitations and Exclusions

Limitations

The plan will not cover expenses for any **prescription drug:**

- for which the actual charge to you is less than the required **copayment** or **deductible**; or
- for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the *Appeals Procedure* section of this Policy.

Exclusions

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Pharmacy Benefit Covers* section. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under the *Medical Benefit Exclusions* section

The plan does not cover the following expenses, including but not limited to:

- [Administration or injection of any drug.
- All drugs or medications in a **therapeutic drug class** if one of the drugs in that **therapeutic drug class** is not a **prescription drug,** unless **medically necessary**.
- Allergy sera and extracts.
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Policy.
- Any **prescription drug** or supply used for the treatment of sexual dysfunction/ enhancement in any form. Any **prescription drug** in any form that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar or identical outcomes.
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Policy. This also includes **prescription drugs** or supplies if:
  - such prescription drug or supplies are unavailable or illegal in the United States;
  - the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.
- Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.
- Biological sera, blood, blood plasma, blood derivatives, or substitutes.
- **Brand name prescription drugs** and devices when a **generic prescription drug** or device equivalent, **biosimilar prescription drug** or **generic prescription drug** or device alternative is available, unless otherwise covered by medical exception.
- Certain **prescription drugs** but only to the extent such coverage is excluded under the plan that you elected and the **preferred drug guide (formulary)**.
- Compounded **prescription**s unless at least one ingredient in the compounded **prescription** is FDA approved]

- [**Cosmetic** drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

- Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

- Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

- Drugs which do not, by federal or state law, require a **prescription** order (e.g., over-the-counter (OTC) drugs), even if a **prescription** is written.

- Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

- Drugs used primarily for the treatment of **infertility**, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Medical Benefit Covers* section.

- Drugs used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications except as described in the *What the Medical Benefit Covers* section.

- Drugs used for the treatment of obesity except as described in the *What the Medical Benefit Covers* section.

- Drugs or medications that include the same active ingredient or a modified version of an active ingredient and:
  - Is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** (unless medical exception is approved), or
  - Is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless medical exception is approved).

- **Durable medical equipment**, monitors and other equipment except as described in the *What the Medical Benefit Covers* section.

- **Experimental or investigational** drugs or devices, except as described in the *What the Medical Benefit Covers* section.

  This exclusion will ***not*** apply with respect to drugs that:
  - Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.]

- [Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. *This limitation will not apply to enteral formulas and special modified food products as specifically stated in this Policy*.

- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

- Growth/Height*:* Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.

- Immunization or immunological agents except as described in the *What the Medical Benefit Covers or What the Pharmacy Benefit Covers* section.

- Implantable drugs and associated devices, except as described in the *What the Medical Benefit Covers or What the Pharmacy Benefit Covers* sections.

- Injectables or infused drugs, except as described in the *What the Medical Benefit Covers or What the Pharmacy Benefit Covers* sections.
  - Any charges for the administration of an infused or injected **prescription drug** or injectable insulin and other infused or injected drugs covered by **Aetna**;
  - Certain injectable agents such as injectable contrasts/dyes used for imaging (e.g., MRI, CT, Bone Scans), except insulin;
  - Needles and syringes except diabetic needles and syringes, or for a covered drug;
  - Injectable drugs if an alternative oral drug is available.

- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

- **Prescription drugs** re-packaged in unit dose form.

- **Prescription drugs** unless the drug is included on the **preferred drug guide (formulary)** or a medical exception is granted.

- **Prescription drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient even if a **prescription** is written, unless **medically necessary**.

- **Prescription** orders filled prior to the effective date or after the termination date of coverage under this Policy.

- **Prescription** orders or refills when in the professional judgment of the pharmacist the **prescription** should not be filled.

- Prophylactic drugs for travel.

- Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

- Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.]

- [Replacement of lost or stolen **prescriptions**.

- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

- Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including but not limited to, hormones and hormone therapy.

- Supplies, devices or equipment of any type, except as specifically provided in the *What the Pharmacy Benefit Covers* or in the *What the Medical Benefit Covers* sections.

- Test agents, except diabetic test agents.

- Tobacco use: Except as described in the *What the Medical Benefit Covers section,* any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.]

Premium Payment

The first premium payment for this Policy is due on or before your Effective Date. Your subsequent premium payment shall be due on the 1st or the 15th of each month based on your Effective Date. Each premium payment is to be paid to **Aetna** on or before the due date. Your premium becomes overdue following the last day of the **premium period**.

A grace period of 31 days will be granted for each premium payment due after the first premium payment. The coverage will remain in force during the grace period.

If your premium is not paid by the end of the grace period, your coverage may be cancelled as of the last day of the grace period, without any previous notification unless expressly required by state law. **Aetna** has the right to require the return of any payments for claims paid during the grace period for which premium was not received. If this Policy is terminated for nonpayment and you request reinstatement, all past due and current premium must be paid in full in order to be reinstated. [In addition, a reinstatement fee may be charged.] **Aetna** may decline reinstatement at our discretion.

In the event a premium payment check is returned or dishonored by the bank as non-payable to **Aetna** for any reason, you may be responsible for an additional charge.

Your premium rate will not change for the initial month of this Policy provided that there are no changes to this Policy, including your area of residence, benefit plan or addition of dependents. However, if there is a change in law or regulation or a judicial decision that has an impact on the cost of providing your covered benefits under this Policy, we reserve the right to change your premium rate during this guarantee period.

Your premium rate is based upon factors such as:

- Type and level of benefit plan;
- Your age and the ages of covered dependents;
- The number of covered persons;
- Tobacco use; and
- Place of residence.

Premium rates are expected to change over time as the cost of healthcare services change. We have the right to change premium rates at any time in the future, subject to applicable regulatory review.

In the event of any changes in premium rates, payment of the premium by the Policyholder shall serve as notice of the Policyholder's acceptance of such changes.

When Coverage Ends

Coverage under your Policy can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends For Covered Persons

Your coverage under this Policy will end if:

- You or your covered dependents no longer meet the eligibility requirements under the Policy;

- Your premium payment is not received by the end of the grace period;
- You terminate your coverage by notifying **Aetna** in writing 31 days in advance of the termination;
- Discontinuance, under federal or state law, of this product in the state if approved by the Insurance Department of the jurisdiction where this Policy was issued;
- **Aetna**'s withdrawal, under federal or state law, from the individual market in the state where this Policy was issued if approved by the Insurance Department of the jurisdiction where this Policy was issued.

Continuing Health Care Benefits

Handicapped Dependent Children

Coverage for your fully handicapped dependent child may be continued past the limiting age for a dependent child.

Your child is fully handicapped if he or she:

- Is not able to earn his or her own living because of a mental or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- Depends on you for support and maintenance.

Proof that your dependent child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the limiting age under your plan. **Aetna** has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap;
- Failure to give proof that the handicap continues;
- Failure to have any required exam;
- Termination of dependent coverage as to your child for any reason other than reaching the limiting age under your plan.

Extension of Benefits

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses incurred in connection with the **injury** or **illness** that caused the total disability will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness,** you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by training, experience and accomplishment.

Extended Health Coverage

Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 3 months.

When Extension of Benefits End

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other plan with like benefits.

Coverage Termination and/or Rescission

Coverage will not be terminated or rescinded on the basis of changes in a covered person's health status or health care needs.

Aetna may terminate or rescind this Policy in the event that a covered person is found to have made an intentional misrepresentation or committed fraud under this Policy.

If you or your covered dependents (or a person seeking coverage on your behalf) commit fraud or make an intentional misrepresentation of fact in obtaining health insurance coverage under this Policy, **Aetna** may rescind your and/or your covered dependent's coverage. This means the Policy will be cancelled back to your Effective Date.

- If we rescind you and/or your covered dependents coverage back to your Effective Date, all premium paid will be refunded to you. You will be responsible for the cost of services, if any, previously received under this Policy. Providers may bill you directly.
- If your coverage under the Policy is rescinded, **Aetna** will provide you with a 30 day advance written notice prior to the date of the rescission.
- If this Policy is rescinded retroactive to its effective date, you have the right to an internal appeal with **Aetna** and/or the right to a third party review conducted by an independent organization.

If you or your covered dependents commit fraud or make an intentional misrepresentation in using medical and/or pharmacy benefits under this Policy, **Aetna** may terminate you and/or your covered dependent's coverage immediately (e.g., using someone's ID card or allowing someone else to use your ID card to obtain medical or pharmacy benefits under this Policy or adding a non-eligible dependent or spouse to this Policy).

If you or your covered dependents commit fraud or make an intentional misrepresentation related to claims or provide information that is fraudulent relating to claims, **Aetna** may terminate you and/or your covered dependent's coverage.

- If we terminate you and/or your covered dependents coverage, you will be responsible for the cost of services previously received under this Policy. Providers may bill you directly.
- If your coverage under the Policy is terminated, **Aetna** will provide you with a written notice mailed to the address as it appears in our records prior to the termination date in accordance with applicable State law.

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): This is:

(a) A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit.
(b) A denial of eligibility for coverage.
(c) Rescission (retroactive termination) of coverage.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service, supply or **prescription drug** is not **medically necessary**.

An **adverse benefit determination** also means the termination of a covered person's coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State of Nevada Office for Consumer Health Assistance and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations – Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than [24-72] hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within [24-72] hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **network provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you or your authorized representative with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

You have 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The Policyholder's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

[You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.]

*Appeals - **Health Claims***

A review of an **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 60 calendar days of receipt of the request for an Appeal.

Exhaustion of Process

You must exhaust the applicable Level One [and Level Two] processes of the Appeal Procedure before you:

- Contact the State of Nevada Office for Consumer Health Assistance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the State of Nevada Office for Consumer Health Assistance; or
- Establish any:

  litigation;

  arbitration; or

  administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. If **Aetna** has not issued a written decision within 30 days after the date you or your authorized representative, if any, filed a complaint with **Aetna**, and you or your authorized representative have not requested or agreed to a delay, you or your authorized representative may initiate a request for **External Review** and shall be considered to have exhausted **Aetna**'s **complaints** and **appeals** process.

Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination** [because **Aetna** determines that:
- the claim involves medical judgment;
- the care is not **necessary** or appropriate;
- a service, supply or treatment is **experimental or investigational** in nature.]

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna's** decision.

To request an **External Review**, [any of] the following requirements must be met:
- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice [of the denial of a claim] by **Aetna**.

[• Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.]
- You qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and include a copy of the *Request for External Review Form*.

You must submit the written *Request for External Review Form* to the State of Nevada Office for Consumer Health Assistance (OCHA) within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

For a standard **External Review**:
- Within 5 business days after receiving the request for **External Review**, OCHA shall notify you, **Aetna**, and other interested parties that a request for **External Review** has been filed.
- As soon as practical, OCHA shall assign the ERO.
- Within 5 business days after receiving the assignment from OCHA identifying the ERO, **Aetna** shall provide all documents and materials relating to the adverse benefit determination to the ERO.
- Within 5 days after receiving notification from OCHA and the materials from **Aetna**, the ERO will review the materials and notify you if additional information is needed to conduct the review.
- Additional information must be provided to the ERO within 5 days after receiving the request.
- The ERO shall forward a copy of the additional information to **Aetna** within 1 business day after receipt.
- Within 15 days of completing the review, the ERO shall submit a copy of its determination to you.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

For a faster External Review:

- OCHA shall approved or deny a request for faster External Review within 72 hours after it receives proof from your provider that the **adverse benefit determination** concerns:
  - an admission;
  - availability of care;
  - continued stay or health care service for emergency care but has not been discharged; or
  - failure to proceed in an expedited manner may jeopardize your life or health.
- Upon determination that the request is eligible for a faster **External Review**, OCHA shall assign an ERO within 1 business day after approving the request.
- **Aetna** shall provide all documents and information used to make the adverse benefit determination to the ERO within 24 hours after receiving notice from OCHA assigning the request.
- The ERO must complete its review within 48 hours (unless you and **Aetna** agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the ERO must notify you, your **physician**, and **Aetna** of its determination by telephone, followed up in writing within 48 hours.

Faster reviews for **experimental or investigational** treatment can be initiated by oral request to the State of Nevada Office for Consumer Health Assistance. When such oral request for expedited **External Review** is made:

- OCHA will immediately notify **Aetna** of the request for an expedited **External Review**.
- **Aetna** will immediately determine whether the request meets the requirements for review, and shall immediately notify OCHA, you, and your authorized representative, if applicable, of its determination.
- If **Aetna** determines that the request for faster **External Review** does not meet the requirements for review, you or your authorized representative, if any, may appeal **Aetna**'s determination to OCHA, and regardless of whether you appeal the determination, OCHA may still determine that the request is eligible for review and require that it be referred for expedited **External Review**. When OCHA makes such determination, the determination must be made in accordance with the terms of your health benefit plan and is subject to all applicable provisions of the **External Review** process.
- Upon determination that the request for expedited **External Review** meets the requirements for review, OCHA shall immediately assign the ERO, which has been approved by the Commissioner of the State of Nevada Department of Insurance that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the ERO may consider your medical records, the attending health care professional's

recommendation, consulting reports from appropriate health care professionals and other documents submitted by you, your authorized representative, if any, your treating provider, and **Aetna**, and will follow **Aetna's** contractual documents and plan criteria governing the benefits.

- Upon receipt of the notice from OCHA assigning the request, **Aetna** shall immediately provide all documents and information used to make the adverse benefit determination to the ERO.
- The ERO must complete its review within 48 hours (unless you and **Aetna** agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the ERO must notify you, your **physician**, and **Aetna** of its determination by telephone, followed up in writing within 48 hours.

Aetna will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to the ERO. **Aetna** is responsible for the cost of any information **Aetna** sends to the ERO and for the cost of the **External Review**.

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number shown on your ID card.

General Provisions

Assignments
An assignment is the transfer of your rights under this Policy to a person you name. Coverage may be assigned only with the written consent of **Aetna**.

To the extent allowed by law, **Aetna** will not accept an assignment of payment to an **out-of network provider**, including but not limited to, an assignment of:

- The benefits due under this insurance Policy;
- The right to receive payments due under this insurance Policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this insurance Policy.

Benefits Not Transferable
You and/or your covered dependents are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF COVERAGE UNDER THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Confidentiality
Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of this plan and administration of this Policy, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone number.

Conformity with Law
Any provision of this Policy which, on its effective date, is in conflict with any applicable statute, regulation or other law is hereby amended to conform with the minimum requirements of such law.

Change of Residence
If you move to a jurisdiction outside of the State of Nevada, **Aetna** will, upon notification, as of the beginning of the **premium period** in which the change occurs, terminate this Policy. **Aetna** will then issue to you (without lapse in coverage) a policy suitable to the jurisdiction where you then live, if **Aetna** is authorized to issue the policy in that jurisdiction. The premium for the new Policy will be based upon the premium rates for the jurisdiction where you now reside, and the then ages of the covered dependents.

If you move within the State of Nevada, it is your responsibility to notify **Aetna** within 31 days. Premium rates will be adjusted, if necessary, to adjust to your new address and the current ages of your covered dependents, effective at the beginning of the **premium period** following the change of residence.

If you move outside of the State of Nevada and **Aetna** is not authorized to issue a policy in the jurisdiction where you have moved, you can continue your coverage under your existing policy.

The premium for your Policy will be based upon the premium rates of the original jurisdiction where it was issued and/or delivered. Your benefits under your existing policy while residing in a jurisdiction where Aetna is not authorized to issue a new policy may be limited or reduced:

- You may be responsible to pay both in-network and out of network rates for services received
- You will not be able to change your policy, including adding a spouse or dependent(s) or changing your plan benefit levels.

Child only coverage

In the case of child only coverage, the parent or legal guardian in whose name the coverage under the plan is issued is considered the Policyholder. As a parent or legal guardian, the Policyholder has subscribed on behalf of the child for the benefits described in this plan. It is the Policyholder's responsibility to assure a child's compliance with any and all terms and conditions outlined in this Policy.

Consideration

This Policy is issued in consideration of the application and payment of the required premium.

Effect of Benefits Under Other Plans

Non-Duplication of **Aetna** Benefits

If, while covered under this plan, you are also covered by another **Aetna** individual coverage plan:

- You will be entitled only to the benefits of the plan with the greater benefits, and
- **Aetna** will refund any premium charges received under the plan with the lesser benefits covering the time period both plans were in effect. However, any claims payments made by **Aetna** under the plan with the lesser benefits will be deducted from any such refund of premium.

If while covered under this plan, you are also covered under an **Aetna** group plan:

- You will be entitled only to the benefits of the group plan.
- We will refund any premium received under the individual plan covering the period both plans were in effect. However, any claims payments made by **Aetna** under the individual plan will be deducted from any such refund of premium.

Entire Contract - Changes

The Policy, application for coverage, *[Schedule of Benefits]*, *Riders*, *Amendments, Insert A's* and any other attachments are the whole contract. Any change in this Policy, must be approved by an **Aetna** executive officer. Such approval will be endorsed or attached to this Policy. No agent can change this Policy or waive any of its terms.

Insurance Fraud

Insurance fraud occurs when you knowingly and with intent to defraud an insurance company or other person, provide **Aetna** with false information or file a claim for benefits that contains any material false information or conceals for the purpose of misleading information concerning any material fact. It is a crime if you commit insurance fraud and may subject you to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of

insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and penalties. **Aetna** shall have the right to use all means available to us to detect, investigate, deter and prosecute those who commit insurance fraud. **Aetna** shall have the right to pursue all legal remedies if you and/or the Policyholder perpetrate insurance fraud.

Incontestability

Except as to a fraudulent misstatement, or issues concerning premiums due:

- No statement made by you or your covered dependent shall be the basis for terminating or rescinding coverage or denying coverage or be used in defense of a claim unless it is in writing;
- No statement made by you or your covered dependent shall be the basis for terminating or rescinding this Policy after it has been in force for 2 years from its effective date;
- No statement made by you or your covered dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Notice of Claim

Written notice of claim must be given to **Aetna** within 30 days after a covered medical expense is incurred, or as soon as reasonably possible. Notice given by or for the Policyholder to **Aetna** at Hartford, Connecticut, or to an authorized **Aetna** agent identifying the Policyholder, will be considered notice.

Other Insurance Coverage

If the covered person has insurance coverage with another insurer acquired after the effective date of this Policy, and the double coverage is permitted by the applicable state laws, we will only pay benefits for **covered expenses** that exceed the benefits payable under the other coverage.

Payment of Benefits

Benefits will be paid immediately upon receipt of the claim and the necessary proof to support the claim. Written proof must be provided for all benefits. All benefits are payable to you. However, **Aetna** has the right to pay any health benefits to a **network provider**. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Any unpaid balance (at the end of **Aetna's** liability as to health expense benefits) will be paid within 30 days of receipt by **Aetna** of the due written proof. If the claim has not been paid, or has not been denied for valid and proper reasons, by the end of the 30 day period, **Aetna** will pay the insured or claimant interest on accrued benefits at a rate equal to the prime rate at the largest bank in Nevada as ascertained by the Commissioner of Financial Institutions on January 1 or July 1, as the case may be, immediately before the date on which payment was due, plus 6%. The interest is calculated from 30 days after the date on which the claim is approved until the date on which the claim is settled.

If **Aetna** requires additional information to determine whether to approved or deny the claim, **Aetna** shall notify you within 20 days of receiving the claim that additional information is

needed. **Aetna** will also notify the provider of all of the specific reasons for the delay in approving or denying the claim. **Aetna** shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, **Aetna** shall pay the claim within 30 days after receiving the additional information. If the approved claim is not paid within this time period, **Aetna** will pay the insured or claimant interest on accrued benefits at a rate equal to the prime rate at the largest bank in Nevada as ascertained by the Commissioner of Financial Institutions on January 1 or July 1, as the case may be, immediately before the date on which payment was due, plus 6%.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a **network provider** provides care to you or a covered dependent, the **network provider** will take care of filing claims for you. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Physical Examinations and Evaluations

Aetna will have the right and opportunity to have a **physician** or **dentist** or other medical or vocational professional of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Receipt of Information

Aetna is entitled to receive from any provider of service information about a covered person which is necessary to administer claims. By submitting an application for coverage, every provider who has furnished or is furnishing care is authorized to disclose all facts, opinion or other information pertaining to care, treatment, and physical conditions of covered persons, upon **Aetna**'s request. You agree to assist in obtaining this information if needed. Failure to assist **Aetna** in obtaining the necessary information when requested may result in the delay or rejection of claims until the necessary information is received.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services;
- Dates expenses are incurred;
- Copies of all bills and receipts.

Recovery of Overpayments

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Relationship of Parties

Aetna is not responsible for any claim for damages or injuries suffered by the covered person while receiving care from any **network provider** or any **out-of-network provider**.

Reporting of Claims

You are required to submit a claim to **Aetna** in writing. **Aetna**, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Your claim must give proof of the nature and extent of the loss. You must furnish true and correct information as **Aetna** may reasonably request. At any time, **Aetna** may require copies of documents to support your claim. You must also provide **Aetna** with authorizations to allow it to investigate your claim and your eligibility. A claim must be submitted to **Aetna** in writing within 90 days of the date of service.

If, through no fault of a covered person, he or she is not able to meet the deadline for filing a claim, the covered person's claim will still be accepted if it is filed as soon as possible. Unless a covered person is legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Successor Policyholder

If the Policyholder ceases to be the insured other than by termination of the Policy, the Policyholder's covered spouse or domestic partner, if any, will become the Policyholder. In the case of a covered dependent child, the parent or legal guardian in whose name the coverage under the plan is issued is considered the Policyholder. If at the end of a **premium period** there is no Policyholder, this Policy will terminate.

Type of Coverage

Only **non-occupational injuries** and **non-occupational illnesses** are covered under this plan unless you are self-employed or a sole proprietor.

Terms of Coverage
In order for covered persons to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the covered person incurs a charge for the service or supply.

The benefits to which a covered person may be entitled will depend on the terms of coverage on the date a charge is incurred for the service or supply.

Waiver
Aetna's failure to implement or insist upon compliance with any provision of this Policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Workers' Compensation
If benefits are paid by **Aetna** and **Aetna** determines you received worker's compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna** will exercise its right to recover against you.

The recovery rights will be applied even though:

- The worker's compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of worker's compensation due to medical or health care is not agreed upon or defined by you or the worker's compensation carrier; or
- The medical or health care benefits are specifically excluded from the worker's compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Policy, you will notify **Aetna** of any worker's compensation claim you make, and that you agree to reimburse **Aetna** as described above. If benefits are paid under this Policy and you or any covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or any covered dependent an amount equal to the amount **Aetna** paid.

Additional Provisions
The following additional provisions apply to your coverage.

- This Policy applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Biosimilar Prescription Drugs
A biological **prescription drug** that is accepted/approved by the U.S. Food and Drug Administration (FDA) as therapeutically similar to a drug with a proprietary name assigned to it by the manufacturer and so indicated by Medi-span or similar publication designated by **Aetna**.

Brand-Name Prescription Drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medi-Span or similar publication designated by **Aetna**.

Calendar Year
This is a twelve-month period starting each January 1 at 12:01 a.m. local time.

Coinsurance
Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" or the "payment percentage," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Copayment (Copays)
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical and **prescription drug** services and supplies shown as covered under this Policy.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering oral medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous feedings);
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform;
- Any service that can be performed by a person without any medical or paramedical training.

Day Care Treatment
Day care treatment is a **partial hospitalization treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment**. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your **covered expenses** that you pay before the plan starts to pay benefits. Additional information regarding **deductible**s and **deductible** amounts can be found in the *[Schedule of Benefits]*.

Dental Provider

This is:
- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person;

that is legally qualified to furnish dental services or supplies.

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification
The process by which an alcohol- or drug-intoxicated, or alcohol- or drug-dependent, person is assisted through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory
This is a listing of all **network providers**. A current list of **network providers** is also available through **Aetna**'s on-line provider **directory**, [DocFind®, at www.docfind.com]. Copies of this **directory** may be furnished to you.

Durable Medical and Surgical Equipment (DME)
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- suited for use in the home;
- Not normally of use to covered persons who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature;
- Not for exercise or training.

Examples of items that are not considered **durable medical equipment** are: whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency Admission
An admission to a **hospital** or **residential treatment facility** by a **physician** who admits you right after the sudden and, at that time, unexpected onset of an **emergency medical condition**, which requires confinement right away as a full-time inpatient.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate, stabilize and treat an **emergency medical condition**.

Emergency Medical Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health,

to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing the covered person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

E-visit

An **E-visit** is an online internet consultation between a network **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet **E-visit** service vendor.

Experimental or Investigational Procedures

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

Generic Prescription Drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medi-span or similar publication designated by **Aetna**.

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy;
- Has full-time supervision by a **physician** or an **R.N.**;
- Keeps complete medical records on each person;
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for continued care and treatment of an **illness** or **injury** [after discharge from a **hospital** or[if you are **homebound**.

The care and treatment must be:

- For the same or related condition that required the **hospital stay**; and
- Prescribed in writing by the attending **physician** within 7 days from the **hospital** discharge; and
- An alternative to a **hospital** or **skilled nursing facility stay.**

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:

- One **physician**;
- One **R.N.**; and
- One licensed or certified social worker employed by the agency.

- Establishes policies about how **hospice care** is provided;
- Assesses the patient's medical and social needs;
- Develops a **hospice care program** to meet those needs;
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;
- Uses volunteers trained in providing services for non-medical needs;
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility or distinct part of one that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons;
- Charges patients for its services;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program including reviews by **physician**s other than those who own or direct the facility;
- Is run by a staff of **physician**s. At least one staff **physician** must be on call at all times;
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**;
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physician**s;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization/Hospitalized

Is necessary and continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- A woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- A woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen **occurrence** or event; or
- The reasonably unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place. An **injury** is not the direct result of **illness**.

Institute of Excellence™ (IOE)

A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants and/or procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants and/or procedures for which it has signed a contract.

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical or vocational nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum Out-of-Pocket Limit

The **maximum-out-of-pocket limit** is the maximum amount you are responsible to pay for **covered expenses** during the **calendar year**. Your **deductibles**, **coinsurance**, **copayments** and other eligible out-of-pocket expenses apply to the **maximum out-of-pocket limit**.

Medically Necessary/Medical Necessity

Health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease;
- Not primarily for the convenience of the patient, **physician**, other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker.

A **mental disorder** includes; but is not limited to:

- **Substance abuse**.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- [Pervasive Mental Developmental Disorder (including Autism).]
- Psychotic depression.
- Schizo-afftective disorder;
- Schizophrenia.

For the purposes of benefits under this plan, **mental disorder** will include **substance abuse** only if any separate benefit for a particular type of treatment does not apply to **substance abuse**.

Morbid Obesity

This means a **body mass index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes. **Body mass index** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Negotiated Charge

As to Health Expense Coverage, (other than Prescription Drug Expense Coverage):
The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide (formulary)**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Pharmacy

A retail **pharmacy**, **mail order pharmacy** or **specialty network pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, to furnish services and supplies for this plan.

Network Provider

A health care provider, **pharmacy** or **dental provider** that has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for the service or supply involved.

Network Services or Supplies

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **primary care physician (PCP)**.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be **non-occupational** regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)

A **prescription drug** or device that is not listed in the **preferred drug guide (formulary)**. This includes **prescription drugs** and devices that might be initially excluded from coverage but may be approved my medical exception.

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A **surgical procedure** to correct malocclusion.

Out-of-Network Pharmacy

A **pharmacy** that has not contracted with **Aetna,** an affiliate, or a third party vendor and does not participate in the **pharmacy** network.

Out-of-Network Provider

A health care provider, **pharmacy** or **dental provider** that has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

Out-of-Network Services and Supplies

Health care service or supply that is:

- Furnished by an **out-of network provider**
- Not furnished or arranged by your **primary care physician (PCP)**.

Partial Hospitalization Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **substance abuse**, or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis;
- It is in accord with accepted medical practice for the condition of the person;
- It does not require full-time confinement;
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect;
- **Day care treatment** is considered **partial hospitalization treatment**.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty network pharmacy**.

Physician

A duly licensed member of a medical profession who:

- Has an M.D., D.O., or D.P.M. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate including a chiropractor, a clinical professional counselor, a marriage and family therapist, a registered nurse (R.N.), a psychologist, an associate in social work, a social worker, an independent social worker and a clinical social worker, and for the practice of acupuncture and herbal medicine a person who is licensed to practice oriental medicine. ("Oriental medicine" means that system of the healing art which places the chief emphasis on the flow and balance of energy in the body mechanism as being the most important single factor in maintaining the well-being of the organism in health and disease.).

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**;
- A **physician** is not you or related to you.

Precertification, Precertify, Precertified

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient services, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that you were not eligible for benefits at that time.

Preferred Drug (Formulary)

A **prescription drug** or device that is listed on the **preferred drug guide (formulary)**.

Preferred Drug Guide (Formulary)

A listing of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide (formulary)** will be available upon your request or may be accessed on the **Aetna** website at [www.aetna.com].

Preferred Drug Guide Exclusions List

A list of **prescription drugs** and devices in the **preferred drug guide (formulary)** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna** or an affiliate.

Premium Period

The **premium period** is the span of time which begins at either the 1st or 15th of the month based on your Effective Date and ends 30 days later.

Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without **prescription**." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general practitioner, family **physician**, internist, pediatrician and, if available within the network, an obstetrician or gynecologist;
- Maintains continuity of patient care; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **substance abuse** or **mental disorders**;
- Is not mainly a school or a custodial, recreational or training institution;
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required;
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly;
- Is staffed by **psychiatrists** involved in care and treatment;
- Has a **psychiatrist** present during the whole treatment day;
- Provides, at all times, **psychiatric** social work and nursing services;
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**;
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**;
- Makes charges;
- Meets licensing standards.

Psychiatrist

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **substance abuse** or **mental disorders**.

Recognized Charge

The covered expense is only the part of a charge which is the **recognized charge.**

As to medical and vision expenses, the **recognized charge** for each service or supply is the lesser of what the provider bills or submits for that service or supply; and

- for professional services and other services or supplies not mentioned below, [90% - 400%] of the Medicare Allowable Rate for the Geographic Area where the service is furnished.
- for inpatient charges of **hospital**s and other facilities, [90% - 400%] of the Medicare Allowable Rate, for the Geographic Area where the service is furnished.

- for outpatient charges of **hospital**s and other facilities, [90% - 400%] of the Medicare Allowable Rate, for the Geographic Area where the service is furnished.

As to **prescription** drug expenses, the **recognized charge** for each service or supply is the lesser of what the provider bills or submits for that service or supply and [50% - 200%] of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

As to dental expenses, the **recognized charge** for a service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- [the 50th - 100th percentile of the Prevailing Charge Rate;]

- [100% - 400% of the Dental Fee Schedule Rate (DFSR);]

for the Geographic Area where the service is furnished.

Aetna may also reduce the **recognized charge** by applying **Aetna** reimbursement policies. **Aetna** reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna reimbursement policies are based on **Aetna**'s review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physician**s and **dentist**s practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Medicare Allowable Rates [and Prevailing Charge Rates] [and Dental Fee Schedule Rates (DFSR),] are defined as follows:

Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

Medicare Allowable Rates: Except as specified below, these are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. **Aetna** updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

Exceptions:

1. For inpatient services, the Medicare Allowable Rate excludes amounts CMS allocates for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) or for other payments which CMS may make directly to **hospital**s.
2. For professional behavioral health services, the allowable rate will be a percentage of the otherwise applicable Medicare Allowable Rate for the following types of providers: **physician**s – 100%; clinical psychologists – 80%; social workers – 60%.

[Prevailing Charge Rates: These are rates reported by Fair Health which is a non profit company. Fair Health has a Medical Data Research (MDR) database which is compiled from information that **Aetna** and other insurers submit to Fair Health for their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within [90-180 days] after receiving them from FAIR Health.]

[Dental Fee Schedule Rates (DFSR): The schedule of rates developed by **Aetna** using **Aetna** data or experience for out of network dental services and supplies provided in the geographic area in which you receive the service or supply. For purposes of this definition "geographic area" means an expense area grouping defined as either:

- the first three digits of the U.S. Postal Service zip codes; or
- a geographic area with similar demographic data or experience.

Aetna reviews and, if necessary, adjusts this schedule periodically.]

Important Notes:
Aetna periodically updates its systems with changes made to the Medicare Allowable Rates [and] [Dental Fee Schedule Rates (DFSR)].

What this means to you is that the **recognized charge** is based on the version of the schedule rates or table that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information

Aetna's website [www.aetna.com] may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** [Navigator] to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact Member Services at the toll free number on your ID Card for assistance.

R.N.

A registered nurse.

Residential Treatment Facility (Substance Abuse)

This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Have the ability to involve family and/or support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care that is consistent with the patient's **illness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.), must be actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R**.**N**. must be onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

Residential Treatment Facility (Mental Disorders)

This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;

- Have the ability to involve family/support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care must be consistent with the patient's **illness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient must be treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Room and Board

Charges made by an institution for **room and board** and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Self Injectable Drugs

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional 24-hour nursing care by a n **R.N.,** or by an **L.P.N.**, directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Is supervised full-time by a **physician** or **R.N.** ;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for the mentally challenged, for custodial or educational care, or for care of **mental disorders**;
- Charges patients for its services;

- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law;
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled Nursing Facility does not include:

- Institutions which provide only:
  - Minimal care;
  - **Custodial care** services;
  - Ambulatory services; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of substance abuse or **mental disorders**.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license;
- The services are not custodial.

Specialist

This is a **physician** who:

- Practices in any generally accepted medical or surgical sub-specialty; and
- Is providing other than routine care.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Specialty Care Prescription Drugs

Specialty care prescription drugs include injectable, infusion and oral drugs prescribed to address complex, chronic diseases which are listed in the **specialty care prescription drug** list. It also includes **biosimilar prescription drugs**. A copy of the **preferred drug guide (formulary)** will be available upon your request or may be accessed on the **Aetna** website at [www.aetna.com].

Specialty Network Pharmacy

A network of **pharmacies** designated to fill **prescriptions** for **self-injectable drugs** and **specialty care prescription drugs**.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna**. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at [www.aetna.com].

Substance Abuse

Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. (This is defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your insured dependents.)

Surgery or Surgical Procedure

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Is licensed as an ambulatory surgical facility;
- Is set up, equipped and run to provide general **surgery**;
- Charges for its services;
- Is directed by a staff of **physician**s. At least one of them must be on the premises when **surgery** is performed and during the recovery period;
- Has at least one certified anesthesiologist at the site when **surgery** which requires general or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to:
  - **physician**s who practice **surgery** in an area **hospital**; and
  - **dentists** who perform oral **surgery**.
- Has at least two operating rooms and one recovery room;
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with **surgery**;
- Does not have a place for patients to **stay** overnight;
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**;
- Is equipped and has trained staff to handle medical emergencies.

It must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation, a defibrillator, a tracheotomy set, and a blood volume expander;

- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them;
- Provides an ongoing quality assurance program. The program must include reviews by **physician**s who do not own or direct the facility; and
- Keeps a medical record on each patient.

Terminally Ill

Terminally ill means a medical prognosis of 6 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available;
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours;
  - Makes charges;
  - Is licensed and certified as required by any state or federal law or regulation;
  - Keeps a medical record on each patient;
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility;
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times;
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden **illness, injury** or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- Includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a **hospital**; and
- Requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **illnesses** and **injuries;**
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**.

Neither:

- An emergency room; nor
- The outpatient department of a **hospital**;

shall be considered a **Walk-in Clinic**.

Contact Us:

Throughout this Policy, there are statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your benefits, please contact us. We look forward to assisting you.

Online
Visit our website
[www.aetna.com]

[Aetna Navigator
www.aetnanavigator.com]

[DocFind®
www.docfind.com]

Aetna Specialty Rx
[www.aetnaspecialtycarerx.com]

Telephone
Please contact **Aetna** at the toll-free number on the back of your ID card.

Mail
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P.O. Box 730
Blue Bell, PA 19422]